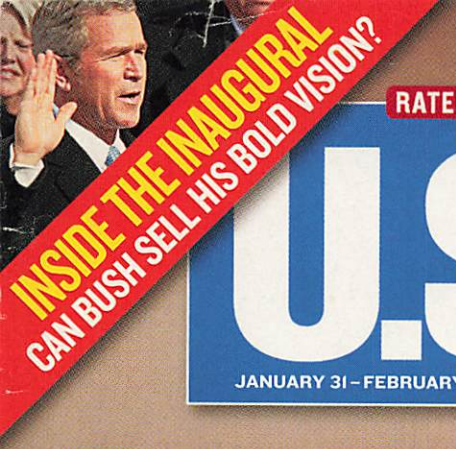

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SPECIAL HEALTH ISSUE

WHO NEEDS DOCTORS?

Your future physician might not be an M.D.—and you may be better off

Lara Bartley, R.N., Oncology Nurse,
Hillman Cancer Center,
University of Pittsburgh Medical Center

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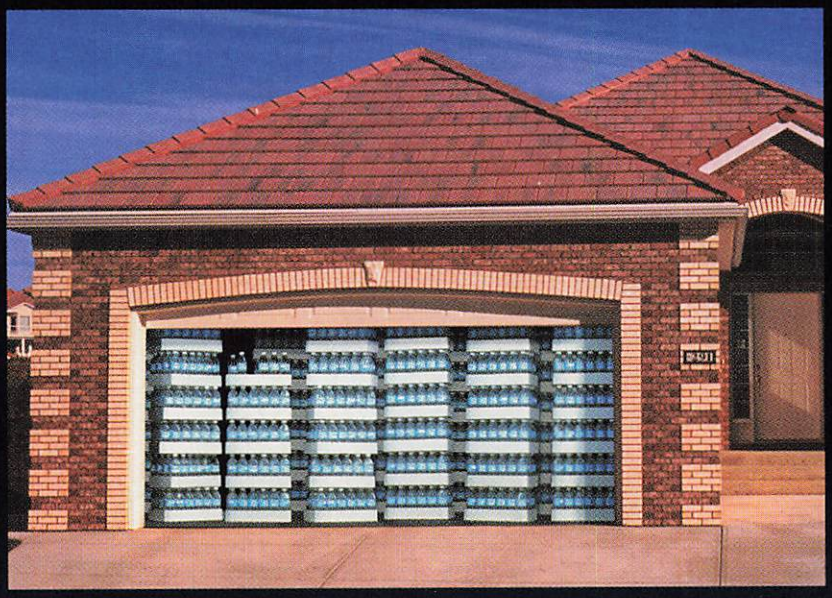

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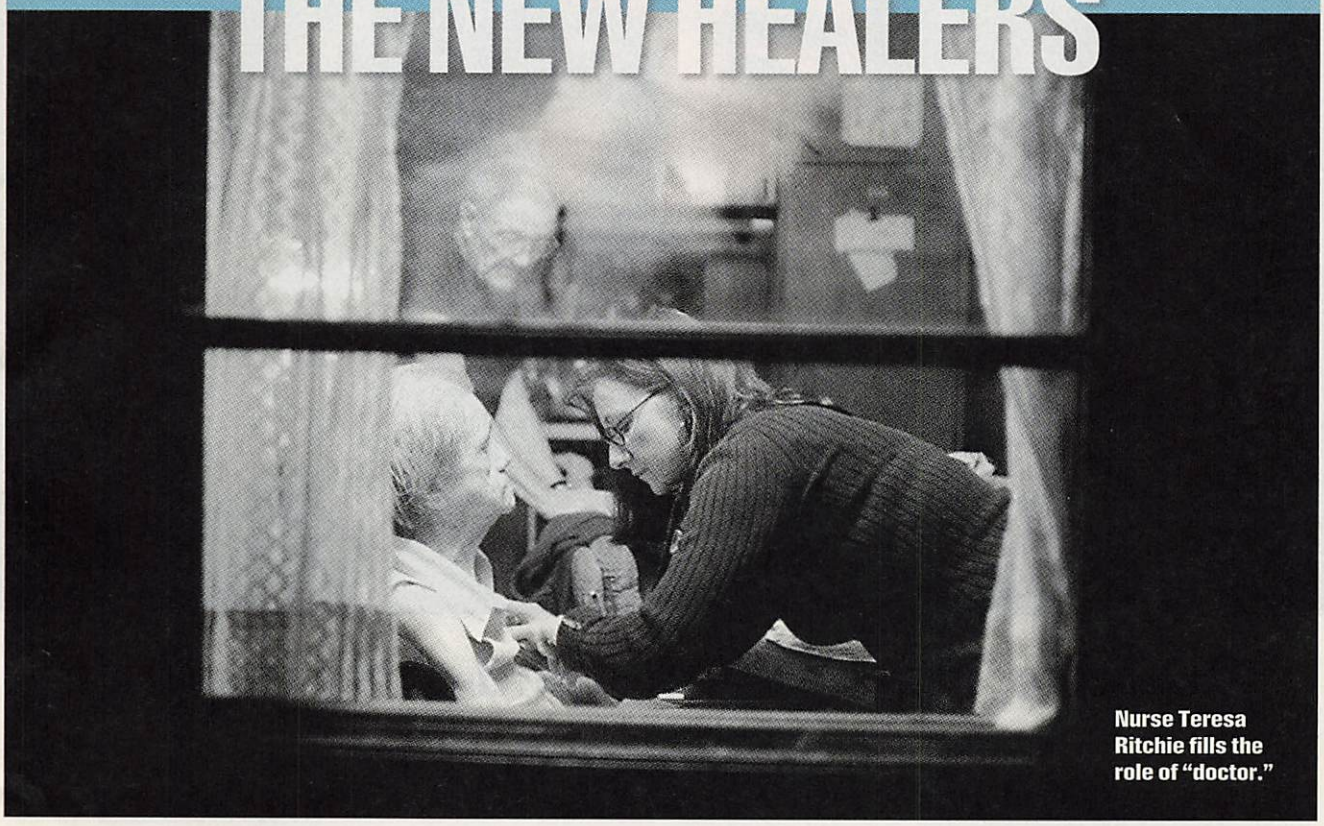

Nurse Teresa Ritchie fills the role of "doctor."

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COVER: PHOTOGRAPH BY SCOTT GOLDSMITH FOR *USN&WR;* (INSET) CHARLIE ARCHAMBAULT FOR *USN&WR*

*BY THE PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS

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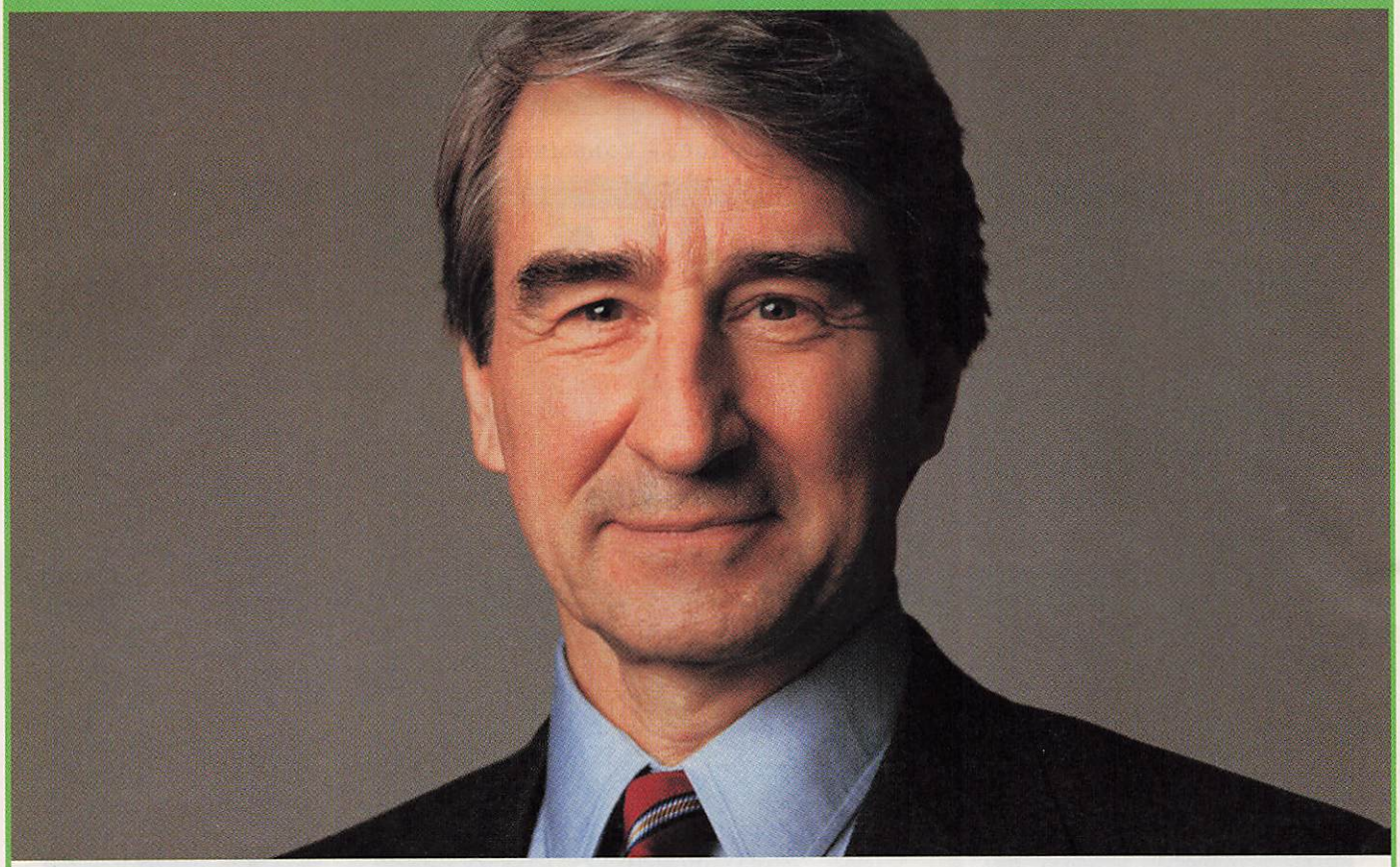

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Washington Whispers

BY PAUL BEDARD

Al Franken TV: a pinch of Stern, a dash of Imus

He hasn't even been on the radio for a year, and liberal funnyman and commentator **Al Franken** is greatly expanding into big-city markets like Washington. But we hear that there's more in store. In D.C. last week to crash **President Bush**'s inaugural, Franken told us that he's in the final stages of negotiating a long-term contract with the Sundance Channel, the same outfit that temporarily aired his radio show up to Election Day. Franken, the face of the lefty Air America radio network, is thinking big when it comes to TV. Like **Howard Stern** and **Don Imus** big. Both of those jocks have popular TV outlets for their radio shows, and Franken eyes borrowing a little from each. "It's sort of halfway in between what Imus does, which is literally a live show on MSNBC, and what Stern does," Franken said, explaining his grand plan. What Stern does, he added, is tape his show and reair it a few weeks later with lots of cool graphics. What Franken wants to do is an Imus-Stern combo: Tape his radio show, edit it, then air a shortened but snazzed-up version on Sundance that night.

BUBBA FOR ARNOLD

Here's the long shot of the year: Congressional Democrats will OK a constitutional amendment allowing naturalized citizens like California Gov. **Arnold Schwarzenegger** to run for president if Republicans help kill the 22nd Amendment barring third terms, thus clearing the way for another bid by **Bill Clinton** and, presumably, **President Bush.** Right now it's the talk among political strategists, but look for it to spread on Capitol Hill when Sen. **Orrin Hatch** reintroduces his plan to let naturalized citizens run for president after 20 years.

A LOSING PROPOSITION

Newly elected Republican Sen. **Tom Coburn** raised eyebrows last fall for claiming that "rampant lesbianism" in parts of his native Oklahoma had some high schools adopting a one-at-a-time rule in the ladies' room. But don't look for him to push for a vote to ban gay marriage anytime soon. "It doesn't do any good to have another vote that you're gonna lose," Coburn says. "What we have to do," he adds, "is change minds and hearts through careful, compassionate consideration of other people's positions and by putting ours out in a way that says, 'This is *why* we believe this way.' "

INTO THE RING

Sen. **Barbara Boxer**'s whupping of Secretary of State designee **Condi Rice** last week has progressives calling the Californian the go-to politician for the big battles coming down the pike on abortion, the Supreme Court, and civil rights.

REAGAN OFF THE CUFF

It was probably the most quoted political speech of

TEDDY TRIMS TO FIGHTIN' WEIGHT

Fat Actress star and Jenny Craig big mouth **Kirstie Alley** didn't have to take those embarrassing—but lucrative—steps just to figure out a path to weight loss. She could have buzzed big **Ted Kennedy** for tips on how he slashed his girth. Aides won't say just how many pounds the Massachusetts senator has lost, but it's very noticeable and has boosted his energy level. "Oh, he's lost a lot of weight," says an aide. "He's definitely more invigorated." His staff is very hush-hush on *exactly* what his weight is or how the celebrated eater and drinker adjusted his intake, but we do have some details. No. 1, said friends, is the constant coaching from his wife. "When I asked him his secret," revealed a friend, "he said it was **Vicki**." Sweet. But he's also on the low-carb Atkins diet and exercises daily for 30 minutes or so, despite a bad back. What's more, friends say that he avoided the pattern of gaining weight on the campaign trail, actually shedding pounds while stumping for Sen. **John Kerry** last fall. And look out, **President Bush**: Now that Kennedy's in fighting form, he's gunning for you and your agenda.

ILLUSTRATION BY RICHARD THOMPSON FOR *USN&WR*

MICHAEL RAMIREZ / COPLEY NEWS SERVICE / *LOS ANGELES TIMES*

SUDDENLY, THERE IT WAS, SILHOUETTED AGAINST THE BLUE MOON...

any defeated candidate, but we are only now learning that **Ronald Reagan**'s address to Republicans at the 1976 Kansas GOP convention, which nominated **Gerald Ford,** was off the top of the Gipper's head. In the first insider account of the bitter nomination battle by Republican consultant **Craig Shirley,** *Reagan's Revolution: The Untold Story of the Campaign That Started It All,* we learn that Reagan had no remarks ready when Ford asked him to unify the convention. Shirley suggests that the Ford camp hoped that without notecards, Reagan would fall flat on his face. Instead, he gave the concise outline of the conservative politics he would bring to the White House four years later.

WHITE HOUSE FAIRY TALE

Their first date was during **President Bush**'s 2001 inauguration, and it must have gone well. Because White House Communications Director **Nicolle Devenish,** 32, and former Bush-Cheney Deputy Campaign Manager **Mark Wallace,** 37, finally got engaged last week. And not on just any day. Wallace picked the couple's fourth anniversary and Bush's second inauguration to pop the question and offer a huge diamond. "He didn't want to be upstaged by the president," cooed Devenish, "so between the speech and the balls he proposed." After she caught her breath, she said yes. "It's a sweet story," she says. "He's a real prince."

THEIR SIDE OF THE STORY

Turns out *My Life,* former **President Clinton**'s autobiography, won't be the last word on his girl troubles. Come May, a retort of sorts, titled *Their Lives,* is due out and will provide new allegations of harassment. **Eric Jackson,** president of World Ahead Publishing, known for its center-right titles, says the book aims to fill the gaps in *My Life.* Jackson wouldn't identify the author and is trying to dampen news about the book, but his description of the 320-page volume reveals that it will tell the story of eight women "who crossed romantic paths with Bill Clinton" and what happened when they broke it off. Its release is timed to that of the *My Life* paperback.

INSIDE INFORMATION

When bestseller **Brian Haig**'s next thriller comes out, it would be good to remember just who he his and what he knows. As the son of **Alexander Haig,** who hastily took charge of the White House after former **President Reagan** was shot—and who was the target of an assassination attempt himself—Brian might have some inside information to share. Don't take it from us: His PR firm notes that his background provides authenticity in *The President's Assassin,* a page turner that features the killing of the White House chief of staff and a $100 million bounty on the prez.

With Dan Gilgoff and Suzi Parker

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In Quotes

"He's a tough old bird."

NEIL RICHARDS, *a former clerk to Supreme Court Chief Justice William Rehnquist, on the judge's decision, despite his frailness from cancer treatments, to swear in President Bush*

"They say, 'You ran for president, and now you want to do this?' "

HOWARD DEAN, *on running for chairman of the Democratic National Committee*

"He's like E. F. Hutton. When he speaks, everybody listens."

MARY MATALIN, *on former boss Vice President Cheney*

"They say my hair is grayer, but I wonder how gray it would have been otherwise. After all, there's gray in the gene pool."

PRESIDENT BUSH, *on the pressures of the job, referring to the white-haired Barbara Bush*

Sources: *Washington Times, Washington Post, USA Today* (2)

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To enter without purchase or obligation: Hand-print your name, address, city, state, zip, day and evening phone numbers, and the words "Visa Bill Pay Everyday Giveaway Sweepstakes" on a 3" x 5" card, and mail in a stamped #10 envelope to: Bill Pay Everyday Giveaway Sweepstakes, P.O. Box 1282, South Bend, IN 46624-1282. There are fifty-nine (59) daily drawings from which you may choose to enter (1/1/05–2/28/05) and one (1) final Grand Prize drawing from all eligible, non-winning entries received throughout the Sweepstakes Period. **Daily Grand Prize:** Hand-print the date of the daily drawing for which the entry is being submitted on the outside of the envelope. The entry must be postmarked no later than the daily drawing date for which it is being submitted and received no later than seven (7) days thereafter. For entries to be entered in the daily drawing for 1/1/05, the words "January 1, 2005" must be hand-printed on the outside of the envelope, and the entry must be postmarked by 1/1/05 and received by 1/8/05. **Final Grand Prize:** To be entered in the drawing, mail-in entries must be postmarked no later than 2/28/05 and received by 3/7/05. To be considered for the Final Grand Prize drawing only, no date needs to be written on the outside of the envelope. Enter as often as you wish; however, only one entry per postmarked envelope will be accepted. No mechanical reproductions permitted. Entries become the property of Visa U.S.A. Inc. ("Sponsor") and will not be returned.

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3. Drawings: Beginning on or about 1/15/05, one (1) daily Grand Prize drawing will be conducted for each day of the Sweepstakes Period from among all eligible entries received corresponding to the applicable day's drawing. A total of fifty-nine (59) daily Grand Prize drawings will be conducted (each a "Daily Drawing"). The last Daily Drawing will occur on or about 3/12/05. Mail-in entries will be entered into the Daily Drawing corresponding to the date hand-printed on the outside of the envelope. Non-winning entries from a Daily Drawing will not be rolled into subsequent Daily Drawings but will be entered in the final Grand Prize drawing. On or about 3/12/05, a separate final Grand Prize drawing will be conducted from among all eligible, non-winning Daily Drawing entries received throughout the Sweepstakes Period. Sixty (60) Grand Prize drawings will be conducted in total. All drawings will be conducted under the direction of asterisk, an independent judging organization whose decisions are final in all matters related to the drawing.

4. Odds: Estimated odds of winning a Daily Grand Prize are 1:4,077,103; however, actual odds depend upon the total number of eligible entries received corresponding to each Daily Drawing. **Estimated odds of winning the Final Grand Prize are 1: 240,549,063;** however, actual odds depend upon the total number of eligible non-winning Daily Drawing entries received during the Sweepstakes Period.

5. Prizes: Fifty-nine (59) daily Grand Prizes: A $1,000 Visa Gift card or a check in the amount of $1,000. One (1) final Grand Prize: A $1,000 Visa Gift card or a check in the amount of $1,000. Retail Value of each prize: $1,000. Total Prize Pool Value: $60,000.

6. Prize Restrictions: Prizes are not transferable. No substitution of any prize permitted except at the sole discretion of Sponsor. Any portion of prize not accepted by winner will be forfeited. Federal, state, and local taxes on prizes and any expenses relating to the acceptance and use of a prize not specified herein as being awarded are the sole responsibility of winner. Limit one prize per person, household, or address.

7. Prize Claim: Each potential prize winner will be notified by phone and/or a traceable method of delivery, and will be required to complete and sign an Affidavit of Eligibility and Liability Release and, where legal, a Publicity Release, both of which must be returned within seven (7) days of receipt of prize notification or the prize will be forfeited and awarded to an alternate winner. If a prize is won by a person who is not of the legal age of majority in the state of residence ("minor"), the required documents must be confirmed and signed by winner's parent or legal guardian, and the prize will be awarded in the name of his/her parent or legal guardian. In the event of noncompliance with these Official Rules, or if Grand Prize or prize notification is undelivered or returned as undeliverable, the prize will be forfeited and may be awarded to an alternate winner.

8. Additional Terms: By participating, entrants or, if minors, their parents or legal guardians agree to: a.) the Official Rules and the decisions of the judges and Sponsor, which shall be final in all respects; and b.) release, discharge, and hold harmless Visa U.S.A. Inc., Visa International Service Association, their respective Member financial institutions, and each of their respective parent companies, subsidiaries, affiliates, advertising and promotion agencies, including asterisk and Zipatoni, their respective parents, subsidiaries and affiliates, and each of their respective officers, directors, shareholders, agents, and employees of the aforementioned entities (collectively, the "Releasees"), from any liability, claims, or damages arising out of their participation in the sweepstakes and the acceptance, use, misuse, or possession of any prize, including, without limitation, any travel related thereto. By accepting a prize, winner or, if a minor, his/her parent or legal guardian agrees to, where legal, Sponsor's and its designees' use of his/her name and/or likeness for advertising and publicity purposes in any and all media now or hereafter known without compensation and, upon request, will provide consent to such use in writing. As a condition of entering the sweepstakes, participant (or parent/legal guardian if participant is a minor) agrees that: a.) under no circumstances will participant be permitted to obtain awards for, and participant hereby waives all rights to claim, punitive, incidental, consequential, or any other damages, other than for actual out-of-pocket expenses; b.) all causes of action arising out of or connected with the sweepstakes, or the awarding of any prize awarded, shall be resolved individually, without resort to any form of class action; and c.) any and all claims, judgments, and awards shall be limited to actual out-of-pocket costs incurred, but in no event attorneys' fees. Sponsor reserves the right to modify prize award procedures at its discretion.

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10. Winners' List: For the names of the winners, mail a self-addressed, stamped envelope to: Visa Bill Pay Everyday Giveaway Sweepstakes/WL, P.O. Box 812900, Chicago, IL 60681-2900. Requests must be received by 3/7/05. The winners' list will be sent when all drawings have been conducted and all winners have been verified.

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WESLEYAN REVISITED

WHEN DID DIVERSITY BECOME A dirty word? As John Leo writes in "Campus Life, Fully Exposed" [January 10], many of the stories he tells happened years ago. I want to make sure we are clear about what is happening today. Real debate does take place at Wesleyan, and it always has. We are proud of the academically rigorous and diverse learning community here, which includes a range of students of differing racial, socioeconomic, religious, and international backgrounds. These students are here to learn from the faculty and one another so that they can prepare for thoughtful, useful lives in a fast-changing, complex world. Diversity is not an end in itself; it is an educational tool. It is not always easy to make diversity work. But it is the right thing to do. The current issue about fraternities [being pressured to accept women] arises because we want to open up opportunities to everyone on campus. Leo's assertions to the contrary notwithstanding, we are upholding the same standard with regard to all campus programs and facilities. The greatest challenge for any university is to move forward in a way that both respects our distinct histories and allows a free exchange of ideas about our common future. To do so requires a diverse and open campus.

DOUGLAS J. BENNET
President
Wesleyan University
Middletown, Conn.

AS A 1959 GRADUATE OF WESLEYAN, I have over the years watched with sadness the evolution of a school that taught me about liberal thought, yet recognized that I was like most 17-to-21-year-olds—a product of a home environment headed by a mother and a father with traditional values and a nod to Christian ethics and teachings. The faculty and administration realized their role as shepherds for youth still tender as freshmen but ready and anxious to expand their world. The fraternity system generally worked for most, but not all, and an experience in living together, managing a self-governing and financing organization, was a great experience, and the friendships made have lasted 50 years. Your article has taken the lid off the "diversity" scam. Doug Bennet, the president and a classmate, has done a great job with what was put in his lap, but the diversity god has consumed them all.

OWEN B. TABOR, M.D.
Memphis

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AS A 2003 GRADUATE AND A FRATERnity member, I think Wesleyan has tried its hardest to create an imaginary environment. Fraternities are not a problem on campus, and if anything they are a place of reality. They allow students to make real-world decisions, the type of decisions all graduates will face after college—the type of decisions Wesleyan supposedly prepares its students to make after graduation but rarely succeeds in doing.

ADAM L. DIAMOND
New York

I REMEMBER WESLEYAN AS A SCHOOL full of passionate, creative students. History students took pride in unearthing what once was ignored; English students in articulating what no one else had expressed; music students in using techniques that others did not; interdisciplinary students in researching topics that eschewed traditional categories of academic inquiry. What they share is a commitment to channeling their creativity and independence in a way that makes the world a better place. Are these students politically left of center? Not as uniformly as Leo implies. The student newspaper regularly features conservatives and moderates whining paradoxically about how their voices aren't heard, but, yes, liberals and lefties abound. So what? Is political belief the sole criterion by which we define "campus orthodoxy"?

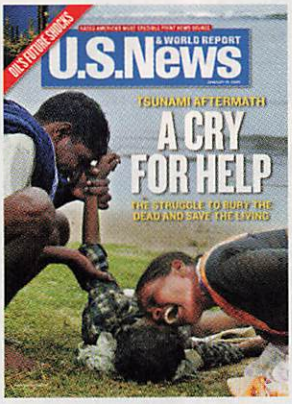
JESSE LAVA
Chicago

LEO'S IMPRESSION OF HIS DAUGHter's experience appears to be the primary basis for his argument. On that level, I am just as expert, and my daughter's experience is different. She is receiving better than a "decent education" and believes that meaningful debate does exist on campus. But Leo's fundamental grievance appears to be more complex than a concern that liberal attitudes substitute for diversity. He presents examples of student experimentation, or excesses, as though they represent university policy. His apparent desire that the institution prohibit such student choices seems inconsistent with his claim that the Wesleyan environment is appropriate only for independent students. Every college struggles with what it should and can control as it provides an environment in which young adults develop independence. Every college has its own examples of student choices that are questionable. Leo may be entitled to choose examples that support his argument; however, he is not entitled to attack an institution unfairly.

EUGENIA GERDES
Lewisburg, Pa.

MY TIME AT WESLEYAN WAS SPENT AS a member of the varsity soccer team and as an economics major. These experiences are far from those of some of the groups and classes Leo speaks negatively about. Wesleyan is a place where the free exchange of ideas not only is encouraged but is nurtured. This ideology is extended to all forms of thought, even conservative ones.

RICHARD FERRI
Warwick, R.I.



TSUNAMI TRAGEDY

THE COVER PHOTOgraph on your January 10 issue was the most wrenching portrait of utter desolation I have ever seen ["A Cry for Help"]. Never has the grief of parents over the death of a child been more graphically captured. It was unforgettable in its impact and perfectly expresses the agony of South Asia's catastrophe.

CARROLL H. OTIS
New York

AS IF THE WORLD DOES NOT HAVE enough suffering and heartache, *U.S. News* showcased the tragedy of the recent tsunami on the cover. As a mother of a young son, I cannot begin to know the grief the family experienced with the loss of their child. No one should have to be a witness to this personal tragedy. As a high school history teacher, I ask my students to view the media with a critical eye. What about a focus on aid organizations, reunions, survivors and their needs, fundraising, or individuals who are making a difference in the wake of this tragedy?

MICHELLE RIBA-DOERR
New Richmond, Wis.

"THE FIGHT FOR LIFE" [JANUARY 17] has two abutting charts telling a powerful tale. At the very bottom of the rich "giving" countries is the sole Muslim nation, Saudi Arabia; at the top of "Deaths

by country" column is the most populous Muslim nation, Indonesia. Maybe the Saudis are saving their money.

RICHARD WILKINS
Syracuse, N.Y.

IT IS INCUMBENT ON THE INTERNAtional community to develop a global early-warning protocol and a system to inform people of any looming threat of natural disasters. The academic community needs to collaborate with the scientific community to develop mathematical computer models to predict the probability of tsunami generation in the event of an earthquake in an ocean. International aid agencies should collaborate with the United Nations to establish permanent regional disaster relief centers (with adequate inventory of relief supplies) in developing countries to minimize the transportation time of relief goods and to provide effective and quick relief to disaster victims.

A. S. KHAN
Addison, Ill.

YOUR COVER STORY ABOUT THE tsunami tragedy highlights the need for the Nuclear Regulatory Commission to take a closer look at existing nuclear power facilities located near faults and/or oceans. A major earthquake and nuclear power meltdown could affect millions living in California or New York. We must learn from the tragedy that just happened in South Asia.

PAUL FEINER
Greenburgh, N.Y.

I GREW UP ON AN ISLAND OF EARTHquakes, volcanoes, and tsunamis. On the big island of Hawaii, when the sirens went off, everyone would rush to the water to see the ocean disappear. One night the tsunami took out half my hometown. No one saw it coming as it ricocheted into Hilo Bay. When it hit the Hamakua coast, the earth shook from the impact and the lights went out, not to come back on again for a long time. With the ongoing reports of the December 26 catastrophe in the Indian Ocean, I dream of things I'd long forgotten like that long drive back to our house, not knowing if it was still there (it was fine). The worry when my dad went out to help during the first weeks. Seeing who didn't come back to school, like the boy in front of me named Lani. Losing miles of stores and my first school. A low tide still makes me want to run for my life.

LEILANI MCCOY
Seattle

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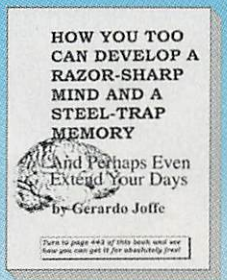

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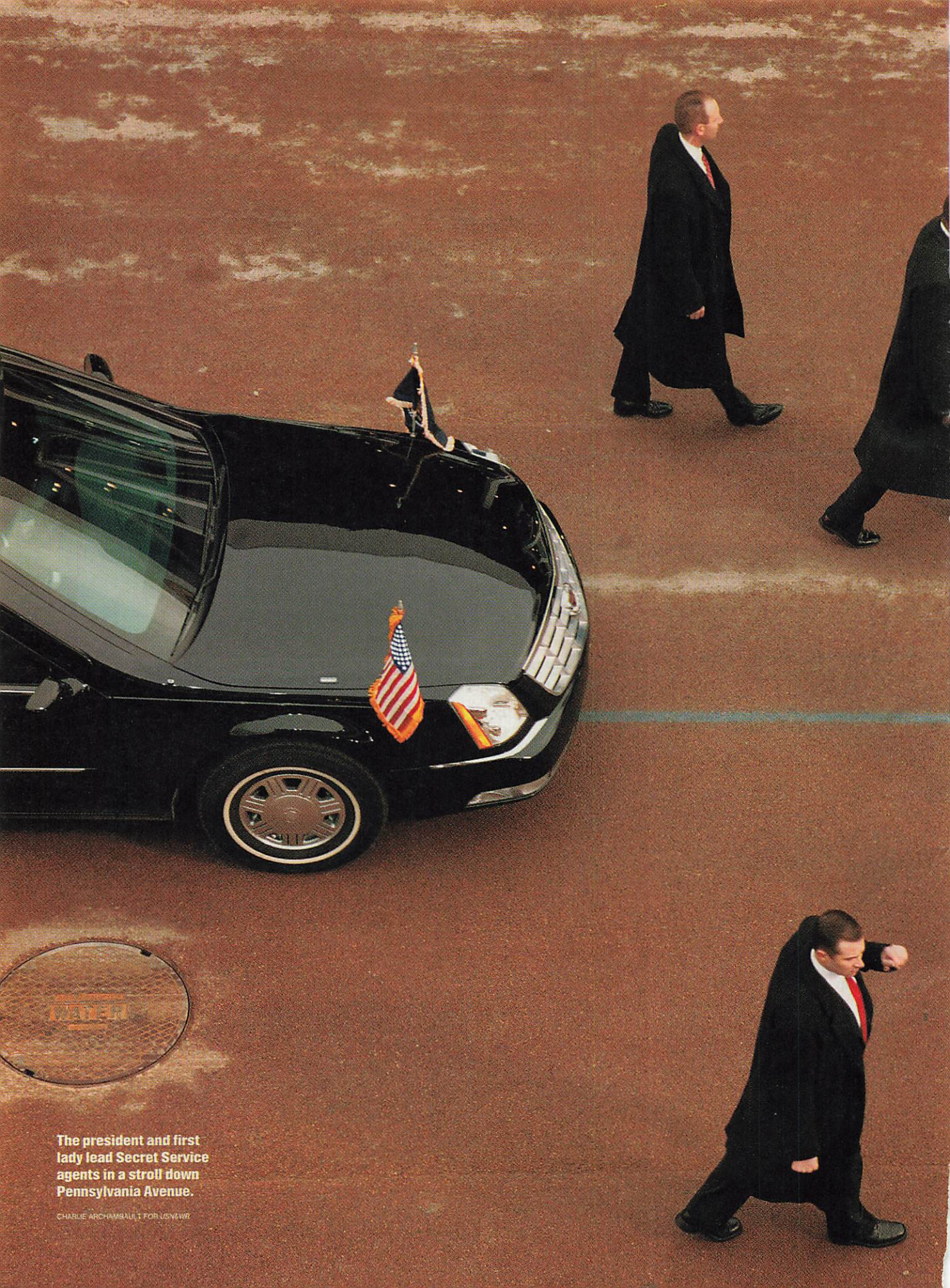
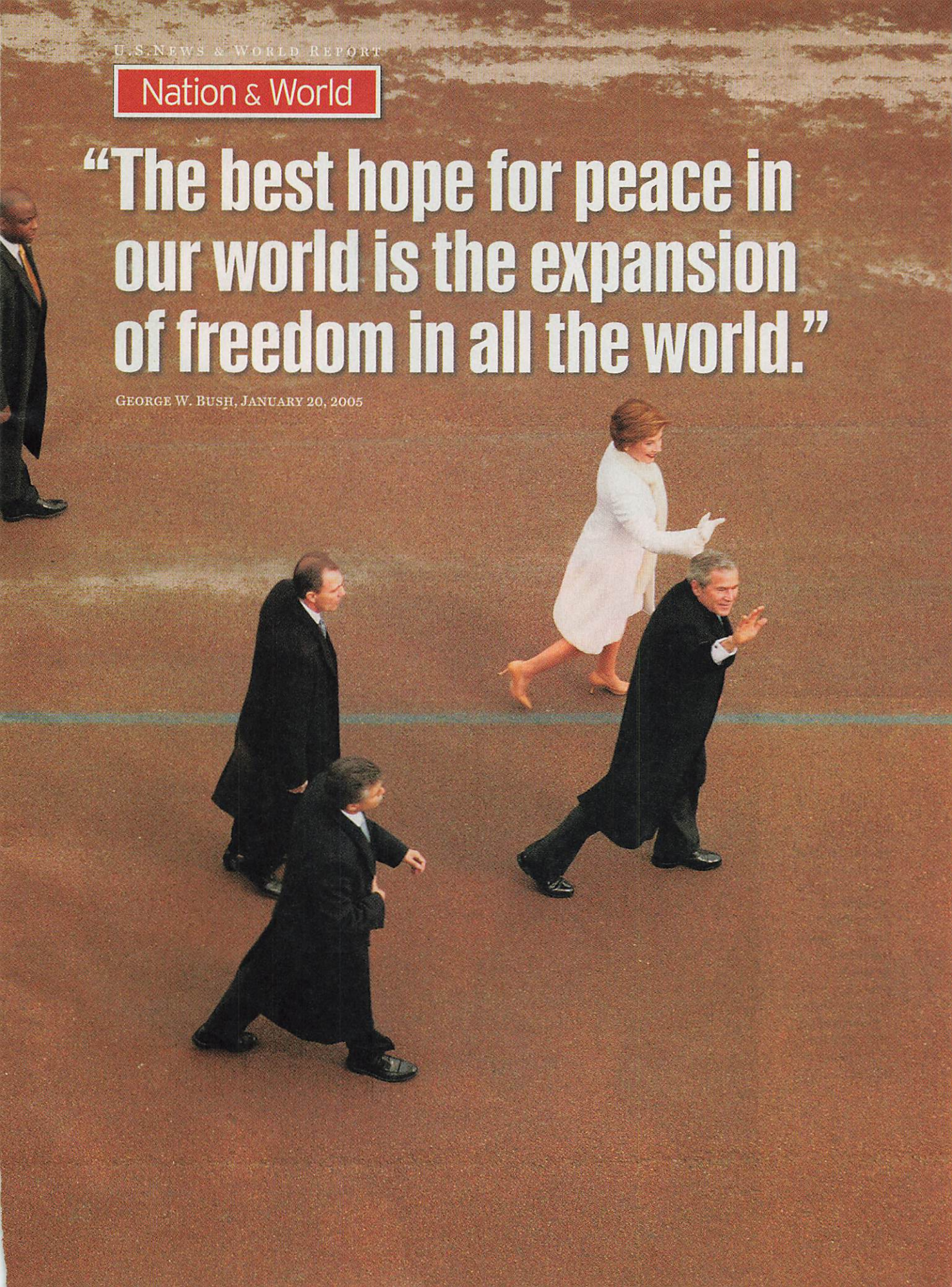


The president and first lady lead Secret Service agents in a stroll down Pennsylvania Avenue.

CHARLIE ARCHAMBAULT FOR USNEWR

"The best hope for peace in our world is the expansion of freedom in all the world."

George W. Bush, January 20, 2005



RITUALS.
Above, stepping out at the Texas State Society's "Black Tie & Boots Ball." Right, outgoing Homeland Security Secretary Tom Ridge and other administration officials listen to the national anthem.

FROM TOP: CHRISTOPHER ANDERSON FOR *USN&WR*; JIM LO SCALZO FOR *USN&WR*

CONTRASTS.
Above, police use pepper spray to keep protesters at bay near the inauguration festivities. Left, good seats were at a premium for the Texas Wyoming Inaugural Ball at the Washington Convention Center.

FROM TOP: JIM LO SCALZO FOR *USN&WR*; CHRISTOPHER ANDERSON FOR *USN&WR*

CENTER STAGE. President Bush took this moment to look back, but the bulk of his inaugural speech was decidedly forward-looking.

A clarion call to end tyranny and spread freedom worldwide

BY KENNETH T. WALSH

It was a day for the true believers—the social conservatives, Christian activists, foreign-policy hawks, and, of course, George W. Bush himself. After taking the oath of office for his second term last week, Bush delivered a 21-minute inaugural address that was as big and blustery as the winter winds that swirled around him on the west front of the Capitol. "All who live in tyranny and hopelessness can know: The United States will not ignore your oppression or excuse your oppressors," he declared. "When you stand for your liberty, we will stand with you." By spreading freedom to other countries, America's freedom will be enhanced, Bush argued, adding: "It is the policy of the United States to seek and support the growth of democratic movements and institutions in every nation and culture, with the ultimate goal of ending tyranny in our world."

Support democracy in *every* nation, in *every* culture, and end tyranny *all over the world*? Bush appeared to be expanding the already massive mission of his presidency, to win the war on terrorism and challenge the "axis of evil" in Iran, North Korea, and Iraq. It sounded like a fundamental rethinking of traditional American foreign-policy principles. At the very least, it was an unexpectedly provocative speech that had foreign diplomats, academics, and journalists scratching their heads to figure out just what it all meant.

There was plenty to ponder. Some wondered, for instance, where the new Bush Doctrine might lead. Was he suggesting a more belligerent attitude toward China, governed by a dictatorship but moving toward a market-oriented economy? In the direction of Russia, where Vladimir Putin has been moving back to a more authoritarian regime? What about Saudi Arabia and Pakistan, valuable allies but ruled by governments that don't subscribe to western democratic ideals?

The details, White House officials say, will be worked out on a nation-by-nation basis. They pointed out, however, that Bush was articulating broad principles and not aiming to unseat friendly regimes in Pakistan and Saudi Arabia but instead pledging to provide financial and other assistance if they move toward democracy. "This is not primarily the task of arms," Bush said. It is also not a short-term task: "The great objective of ending tyranny is the concentrated work of generations."

Furs and heels. Bush also addressed domestic issues with a similar missionary zeal and a religious conviction that is sure to unsettle his critics. "In America's ideal of freedom," he said, "the public interest depends on private character—on integrity, and tolerance toward others, and the rule of conscience in our own lives. Self-government relies, in the end, on the governing of the self." The president repeated his call for an "ownership society" in which government recedes and citizens take more responsibility for their own lives.

His audience, mostly, lapped it up. Women in fancy furs and high heels tried gamely to navigate icy sidewalks around the Capitol, while men in cashmere coats kept a tight grip on their Stetsons. Among those watching the swearing-in were Kayemille and Joey Goss of Fort Worth, Texas—Kayemille

JIM LO SCALZO FOR *USN&WR*

IT'S A WRAP. The president waves as he returns to the White House with family and friends after viewing the inaugural parade.

wearing a long coat tipped in fur and Joey sporting a camel-colored trench coat and a dandyish blue-and-yellow tie. "The main thing that inspires us so much about him [Bush]," Joey said, "is that he is a man that listens to God."

Clair Ellis, a 57-year-old retired marine, leaned on his cane as he offered his reasons for backing Bush. "With 9/11 happening nine months after he took office, it cemented in my mind and heart that he was going to be a good president," said Ellis, who wore a big Russian hat to ward off the cold. Bob Robbins, a 60-year-old state senator from Pennsylvania, said, "We are obviously now in the Third World War. Unfortunately, there are some that don't believe this."

And some of them were in Washington last week, too. The inaugural's estimated $40 million cost was seen by some as extravagant, even though most of it was raised from private sources. And many Democrats stayed away, although defeated presidential challenger John Kerry sat stoically about 30 feet from the podium where Bush spoke. Thousands of protesters dramatized their opposition to the Iraq war and other Bush policies with street theater, angry chants as the president's limousine rolled by, and a tossed snowball or two.

Parts of official Washington resembled an armed camp, with 100 square blocks closed off around the White House and the Capitol and security forces everywhere. As Bush's limo crawled down Pennsylvania Avenue for the parade, it was surrounded by police cars and motorcycles, all with lights flashing, and grim-faced Secret Service agents who trotted vigilantly alongside, scanning the crowd. A few blocks from the White House, Bush and his wife, Laura, emerged from their limo, walked a few hundred yards in the open, and greeted their admirers.

Bold. What will perhaps be remembered most, though, were the bold strokes of the president's address. For some hawkish foreign-policy analysts, the speech was cause for celebration. "It was the clearest, most forceful articulation of the organizing principle of American foreign policy, post 9/11," said Danielle Pletka, vice president for foreign and defense policy studies at the American Enterprise Institute. "Freedom is the answer . . . . We're not safe unless you're free."

"There is no justice without freedom."

For others, though, Bush's call for backing democratic movements everywhere is fraught with peril, especially when applied to states whose relationships with America are based on real-world priorities like fighting terror. "It was a sermon, high on rhetoric, low on substance," said Geoffrey Kemp, director of regional strategic programs at the Nixon Center. Preaching democracy, added presidential scholar Robert Dallek, is an American tradition that goes all the way back to Woodrow Wilson. The question, he said, is whether Bush's version of this "civic religion" is compatible with today's world.

Behind the scenes, the president was pleased that so many people seemed impressed with the breadth of his ideas and his willingness to state them so boldly. Said a senior White House aide, "He's not one to sit around." One way or the other, the next four years will tell whether that vision can be made into a reality. ●

With Dan Gilgoff, Angie C. Marek, and Thomas Omestad

JEFFREY MACMILLAN FOR *USN&WR*

MICHAEL BARONE

Revolutionary president

'BY OUR EFFORTS, WE HAVE LIT a fire," said George W. Bush at the West Front of the Capitol, "a fire in the minds of men. It warms those who feel its power, it burns those who fight its progress, and one day this untamed fire of freedom will reach the darkest corner of the world." The phrase comes from Dostoyevsky's *The Possessed,* a novel about a provincial town inspired by new revolutionary ideas. After a turbulent literary evening, a fire breaks out, and one townsman says, "The fire is in the minds of men, not in the roofs of buildings." Historian James Billington, now librarian of Congress, used the phrase as the title of his history of 19th-century revolutionaries, *Fire in the Minds of Men.* Bush is routinely characterized as a conservative and castigated by political opponents as a reactionary. But in his second inaugural he revealed himself to be a revolutionary.

Four years ago Bush talked of "shaping a balance of power that favors freedom." He said, "Through much of the last century, America's faith in freedom and democracy was a rock in a raging sea. Now it is a seed upon the wind, taking root in many nations." But September 11 taught Bush that America needs to do more than shape a balance of power or let seeds blow with the wind. "The best hope for peace in our world is the expansion of freedom in all the world," he said last week. And, bluntly, "it is the policy of the United States to seek and support the growth of democratic movements and institutions in every nation and culture, with the ultimate goal of ending tyranny in our world."

There is no concession in this to the complaints of his critics, no defensiveness about the course of events, no reference to the counsels of sophisticated nuance. He set out a breathtakingly ambitious goal: to bring democracy to the entire world. One would like to know the reaction of Saudi Ambassador Prince Bandar. Or the Iranian mullahs. Or Vladimir Putin in Moscow. Or China's rulers.

Bush is not the first president to liken liberty to fire. George Washington in 1789 said, "The preservation of the sacred fire of liberty and the destiny of the republican model of government are justly considered . . . deeply, . . . finally, staked on the experiment intrusted to the hands of the American people." In 1941 Franklin Roosevelt quoted Washington and went on, "If we lose that sacred fire—if we let it be smothered with doubt and fear—then we shall reject the destiny which Washington strove so valiantly and so triumphantly to establish." Bush chose to quote Lincoln. "The rulers of outlaw regimes can know that we still believe as Abraham Lincoln did: 'Those who deny freedom to others deserve it not for themselves; and, under the rule of a just God, cannot long retain it.' " There is a narrative here: Washington established liberty in America, Lincoln extended liberty to the slaves, Bush means to spread liberty around the world. And by force of arms when necessary.

Upward mobility. Bush also invoked his predecessors when he spoke about domestic policy. He referred specifically to the Homestead Act, the Social Security Act, and the GI Bill of Rights—the achievements of the other two presidents, Lincoln and Roosevelt, who were re-elected in time of war. Those were laws that aided and encouraged Americans to work their way up in society and achieve independence. Bush argues that his program of "reforming great institutions"—school accountability, Social Security investment accounts, market-based healthcare—will similarly encourage upward mobility and, in words that echo Roosevelt's Four Freedoms, "give our fellow Americans greater freedom from want and fear."

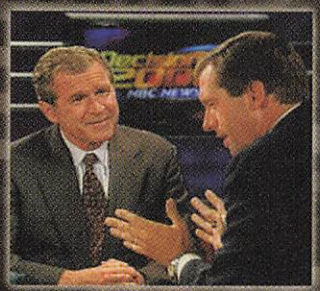
Bush's goals are ambitious, and he risks failure. But so did Lincoln and Roosevelt. "There are men who believe . . . " said Roosevelt, "that freedom is an ebbing tide." Roosevelt didn't, and Bush, echoing his words, made plain he doesn't either. "History has an ebb and flow of justice, but history also has a visible direction, set by liberty and the Author of Liberty." Fire, Billington writes in *Fire in the Minds of Men,* "burns. It destroys life; but it also supports it as a source of heat, light and—above all—fascination." America's revolutionary presidents have changed the nation and the world before. Will this latest revolutionary president do so again? ●

He set out a breathtakingly ambitious goal: to bring democracy to the entire world.

CHARLIE ARCHAMBAULT FOR *USN&WR*

WARM RECEPTION. Bush kissed his daughters after his swearing in, then gave an unexpectedly provocative inaugural address.

REPORTING AMERICA'S STORY



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DEMOCRACY UNDER THE GUN

Preparing to vote, Iraqis wonder if elections will lead to peace or more chaos

BY ILANA OZERNOY

BAQUBAH—On the eve of Iraq's first democratic election, a local television station in this restive city north of Baghdad decided to host a candidates' debate. A handful of prospective politicians were invited to discuss the core issues—deteriorating security, U.S. troops on Iraqi soil, the prospect of democracy in a nation traumatized by war—and the scene was set with hot, white lights and a couple of TV cameras in front of a wall garishly plastered with stickers in Arabic that proclaim, "Everyone ♥ Iraq."

But much like the elections themselves, scheduled for January 30, the exercise was hardly textbook democracy. Most candidates, too afraid to reveal their names and faces on television, didn't show up. Nor did the group of students invited to question them. Still, the show would go on—albeit Iraqi style. Provincial governor Abdullah Rashid al-Jabouri, whose name will appear on local ballots on a candidate list called "Diyala's Elite," sat down for the cameras across from a local representative of the Communist Party. The TV screen flickered with a gory montage of charred bodies, explosions, and U.S. troops stepping over bloodied, dead men, and then it was time to talk politics. "To boycott elections does not serve our people!" Akram Khadouri, the Communist, said into the camera, in hopes of reaching a fearful and disenchanted public who may stay home on election day. "If we all stand together, we can overcome a lot of difficulties."

Nameless and faceless. There's a lot to overcome. More than eight electoral workers have been killed and hundreds threatened with death, including the top electoral official in Mosul, who resigned after his family was threatened. Political assassinations and the threat of car bombs at public gatherings have largely precluded holding political rallies. And unlike most any other election, many of the candidates vying for the 275 seats in

CAUTIOUS CAMPAIGN. In places like Basra (above) speeches and rallies have been more open than in the violent Sunni Triangle area. An election worker (top) moves a ballot box.

FROM TOP: MAYA ALLERUZZO—AFP / GETTY IMAGES / POOL; ESSAM AL-SUDANI—AFP / GETTY IMAGES

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VIAGRA is prescribed to treat erectile dysfunction. We know that no medicine is for everyone. If you use nitrate drugs, often used for chest pain (known as angina), don't take VIAGRA. Taking these drugs together could cause your blood pressure to drop to an unsafe level.

The most common side effects of VIAGRA are headache, facial flushing, and upset stomach. Less common are bluish or blurred vision, or being sensitive to light. These may occur for a brief time. Remember to protect yourself and your partner from sexually transmitted diseases.

Talk with your doctor first. Make sure you are healthy enough to have sex. If you have chest pain, nausea, or other discomforts during sex, seek medical help right away. The same is true if you have an erection that lasts more than 4 hours. Call for help at once.

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* For some men, in as quickly as 10 minutes; for most, in under a half hour (statistical significance at 14 minutes). In this study, VIAGRA responders, given 100 mg 2 hours after eating, were timed to see how fast they got an erection that enabled them to have sex.

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PATIENT SUMMARY OF INFORMATION ABOUT

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This summary contains important information about VIAGRA®. It is not meant to take the place of your doctor's instructions. Read this information carefully before you start taking VIAGRA. Ask your doctor or pharmacist if you do not understand any of this information or if you want to know more about VIAGRA.

This medicine can help many men when it is used as prescribed by their doctors. However, VIAGRA is not for everyone. It is intended for use only by men who have a condition called erectile dysfunction. **VIAGRA must never be used by men who are taking medicines that contain nitrates of any kind, at any time. This includes nitroglycerin. If you take VIAGRA with any nitrate medicine your blood pressure could suddenly drop to an unsafe or life threatening level.**

• What Is VIAGRA?
VIAGRA is a pill used to treat erectile dysfunction (impotence) in men. It can help many men who have erectile dysfunction get and keep an erection when they become sexually excited (stimulated).

You will not get an erection just by taking this medicine. VIAGRA helps a man with erectile dysfunction get an erection only when he is sexually excited.

• How Sex Affects the Body
When a man is sexually excited, the penis rapidly fills with more blood than usual. The penis then expands and hardens. This is called an erection. After the man is done having sex, this extra blood flows out of the penis back into the body. The erection goes away. If an erection lasts for a long time (more than 6 hours), it can permanently damage your penis. You should call a doctor immediately if you ever have a prolonged erection that lasts more than 4 hours.

Some conditions and medicines interfere with this natural erection process. The penis cannot fill with enough blood. The man cannot have an erection. This is called erectile dysfunction if it becomes a frequent problem.

During sex, your heart works harder. Therefore sexual activity may not be advisable for people who have heart problems. Before you start any treatment for erectile dysfunction, ask your doctor if your heart is healthy enough to handle the extra strain of having sex. If you have chest pains, dizziness or nausea during sex, stop having sex and immediately tell your doctor you have had this problem.

• How VIAGRA Works
VIAGRA enables many men with erectile dysfunction to respond to sexual stimulation. When a man is sexually excited, VIAGRA helps the penis fill with enough blood to cause an erection. After sex is over, the erection goes away.

• VIAGRA Is Not for Everyone
As noted above (*How Sex Affects the Body*), ask your doctor if your heart is healthy enough for sexual activity.

If you take any medicines that contain nitrates – either regularly or as needed – you should never take VIAGRA. If you take VIAGRA with any nitrate medicine or recreational drug containing nitrates, your blood pressure could suddenly drop to an unsafe level. You could get dizzy, faint, or even have a heart attack or stroke. Nitrates are found in many prescription medicines that are used to treat angina (chest pain due to heart disease) such as:

- nitroglycerin (sprays, ointments, skin patches or pastes, and tablets that are swallowed or dissolved in the mouth)
- isosorbide mononitrate and isosorbide dinitrate (tablets that are swallowed, chewed, or dissolved in the mouth)

Nitrates are also found in recreational drugs such as amyl nitrate or nitrite ("poppers"). If you are not sure if any of your medicines contain nitrates, or if you do not understand what nitrates are, ask your doctor or pharmacist.

VIAGRA is only for patients with erectile dysfunction. VIAGRA is not for newborns, children, or women. Do not let anyone else take your VIAGRA. VIAGRA must be used only under a doctor's supervision.

• What VIAGRA Does Not Do
- VIAGRA does not cure erectile dysfunction. It is a treatment for erectile dysfunction.
- VIAGRA does not protect you or your partner from getting sexually transmitted diseases, including HIV — the virus that causes AIDS.
- VIAGRA is not a hormone or an aphrodisiac.

• What To Tell Your Doctor Before You Begin VIAGRA
Only your doctor can decide if VIAGRA is right for you. VIAGRA can cause mild, temporary lowering of your blood pressure. You will need to have a thorough medical exam to diagnose your erectile dysfunction and to find out if you can safely take VIAGRA alone or with your other medicines. Your doctor should determine if your heart is healthy enough to handle the extra strain of having sex.

Be sure to tell your doctor if you:

- have ever had any heart problems (e.g., angina, chest pain, heart failure, irregular heart beats, heart attack or narrowing of the aortic valve)
- have ever had a stroke
- have low or high blood pressure
- have a rare inherited eye disease called retinitis pigmentosa
- have ever had any kidney problems
- have ever had any liver problems
- have ever had any blood problems, including sickle cell anemia or leukemia
- are allergic to sildenafil or any of the other ingredients of VIAGRA tablets
- have a deformed penis, Peyronie's disease, or ever had an erection that lasted more than 4 hours
- have stomach ulcers or any types of bleeding problems
- are taking any other medicines

• VIAGRA and Other Medicines
Some medicines can change the way VIAGRA works. Tell your doctor about **any medicines** you are taking. Do not start or stop taking any medicines before checking with your doctor or pharmacist. This includes prescription and nonprescription medicines or remedies:

- Remember, VIAGRA should never be used with medicines that contain nitrates (see *VIAGRA Is Not for Everyone*).
- If you are taking alpha-blocker therapy for the treatment of high blood pressure or prostate problems, you should not take a dose of greater than 25 mg of VIAGRA at the same time (within 4 hours) as you take your dose of alpha-blocker.
- If you are taking a protease inhibitor, your dose may be adjusted (please see *Finding the Right Dose for You*).
- VIAGRA should not be used with any other medical treatments that cause erections. These treatments include pills, medicines that are injected or inserted into the penis, implants or vacuum pumps.

• Finding the Right Dose for You
VIAGRA comes in different doses (25 mg, 50 mg and 100 mg). If you do not get the results you expect, talk with your doctor. You and your doctor can determine the dose that works best for you.

- Do not take more VIAGRA than your doctor prescribes.
- If you think you need a larger dose of VIAGRA, check with your doctor.
- VIAGRA should not be taken more than once a day.

If you are older than age 65, or have serious liver or kidney problems, your doctor may start you at the lowest dose (25 mg) of VIAGRA. If you are taking protease inhibitors, such as for the treatment of HIV, your doctor may recommend a 25 mg dose and may limit you to a maximum single dose of 25 mg of VIAGRA in a 48 hour period. If you are taking alpha-blocker therapy, you should not take a dose of greater than 25 mg of VIAGRA at the same time (within 4 hours) as your dose of alpha-blocker.

• How To Take VIAGRA
Take VIAGRA about one hour before you plan to have sex. Beginning in about 30 minutes and for up to 4 hours, VIAGRA can help you get an erection if you are sexually excited. If you take VIAGRA after a high-fat meal (such as a cheeseburger and french fries), the medicine may take a little longer to start working. VIAGRA can help you get an erection when you are sexually excited. You will not get an erection just by taking the pill.

• Possible Side Effects
Like all medicines, VIAGRA can cause some side effects. These effects are usually mild to moderate and usually don't last longer than a few hours. Some of these side effects are more likely to occur with higher doses. The most common side effects of VIAGRA are headache, flushing of the face, and upset stomach. Less common side effects that may occur are temporary changes in color vision (such as trouble telling the difference between blue and green objects or having a blue color tinge to them), eyes being more sensitive to light, or blurred vision.

In rare instances, men have reported an erection that lasts many hours. You should call a doctor immediately if you ever have an erection that lasts more than 4 hours. If not treated right away, permanent damage to your penis could occur (see *How Sex Affects the Body*).

Heart attack, stroke, irregular heart beats, and death have been reported rarely in men taking VIAGRA. Most, but not all, of these men had heart problems before taking this medicine. It is not possible to determine whether these events were directly related to VIAGRA.

VIAGRA may cause other side effects besides those listed on this sheet. If you want more information or develop any side effects or symptoms you are concerned about, call your doctor.

• Accidental Overdose
In case of accidental overdose, call your doctor right away.

• Storing VIAGRA
Keep VIAGRA out of the reach of children. Keep VIAGRA in its original container. Store at 25°C (77°F); excursions permitted to 15-30°C (59-86°F) [see USP Controlled Room Temperature].

• For More Information on VIAGRA
VIAGRA is a prescription medicine used to treat erectile dysfunction. Only your doctor can decide if it is right for you. This sheet is only a summary. If you have any questions or want more information about VIAGRA, talk with your doctor or pharmacist, visit www.viagra.com, or call 1-888-4VIAGRA.

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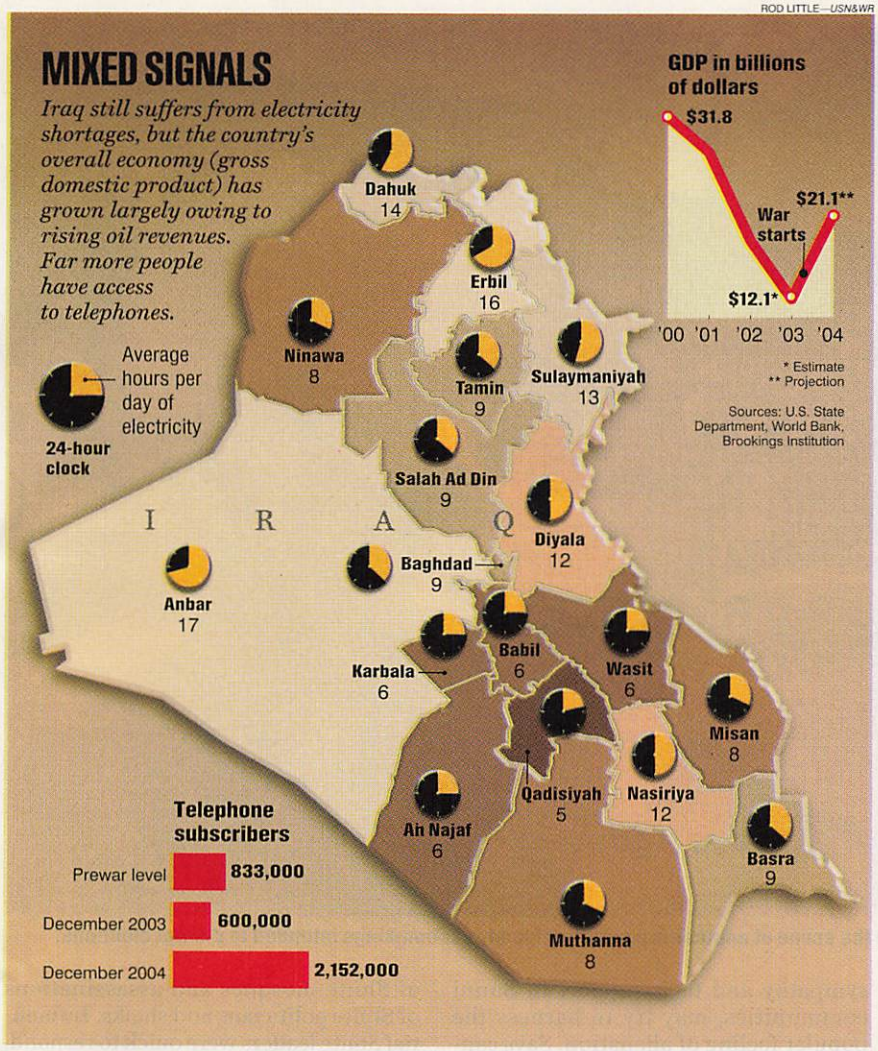

the national assembly—to be tasked with forming the transitional government and writing a constitution—are nameless and faceless to the public who will vote for ad hoc slates cobbled together by political, tribal, and religious leaders.

In some parts of the country, namely the Shiite-dominated southeast and the Kurdish northern region, the conditions are more conducive to elections. But the violence in four largely Sunni Arab provinces is likely to keep a significant number of Iraqis from voting. "The issue is not whether or not I want to vote, but whether the circumstances for that are healthy," said Ziad al-Rawi, 54, a retired Army general. "The elections are not legitimate. How can they happen when cities are bombed, women and sheiks are killed?"

Pulling it off, and making it look right, will be a test not only for U.S. troops but especially for the fledgling Iraqi military, which has been targeted by the insurgency and, as a result, is riddled with desertions. The interim Iraqi government has declared a three-day national holiday around election day, and the roads will be shut down to keep would-be suicide bombers at bay. U.S. troops will provide an outer cordon of security, but it will be up to Iraqis to provide security at the polls. "There will not be an American soldier in a helmet standing there as Iraqis drop the ballot into the boxes," said a western diplomat in Baghdad.

"The Shia are restraining themselves... holding their breath."

ADNAN ALI, *Dawa party official*

A lot is riding—both here and in Washington—on how the election plays out. A credible vote would be a much needed accomplishment for President Bush, who stressed spreading freedom in an inaugural address that omitted specific mention of Iraq. Still, Bush administration officials now recognize that even a successful election would not immediately quell the persistent insurgency. The most they now hope for is a shift in momentum that would allow for an exit strategy and a chance to begin withdrawing some of the 150,000 U.S. troops. "[Elections do] not mean we're getting out. This is not a rapid force exit strategy," said a U.S. Embassy official. "You can't just pull out and leave without forces that can fill the gap."

To some degree, just holding an election may be seen as an achievement. "The fact that this is a transition from an appointed to an elected government—that's the significance," U.S. Ambassador John Negroponte told reporters on January 19. "For the Iraqis to have ownership of their own political process is also an extremely important thing."

When Iraqis go to the polls, they will vote to disperse that ownership among the variety of groups that have emerged on the political playing field—groups that define themselves more along ethnic, religious, and tribal lines than by political or policy platforms. The Shiite and Kurdish camps, whose leaders spent years in exile organizing and plotting to stake their claims, are better prepared to mobilize voters than the Sunni minority, which lacks viable leadership and whose constituency is largely based in the four most violent provinces of Iraq.

One favorable sign is that the Shiites can't wait to vote. After decades of oppression by Saddam Hussein's ruling Sunni minority, Shiite politicians are eager to move forward with the support of an enthusiastic constituency. Listen to the Shiite street and you hear the budding promise of democracy: "Participate in the elections and then afterwards discuss the problems on the table inside the national assembly. There is no need for bloodshed and the use of weapons," says Abdul Amir Jassem, a fast-talking medical student.

For the Sunnis, the political future is less certain. Between the threat of election-day violence and the fear of retaliation by neighbors after the vote, it is likely that on election day many Sunnis will simply stay home. "The Sunni Arab voters want to go to the polls [but] they are being intimidated by people who do not believe in the elections," says Sharif Ali bin Hussein, leader of the Constitutional Monarchy party and descendent of Iraq's deposed monarch. The result, Hussein says, is that "the government will

EVIDENCE OF INTIMIDATION. Troops secure the scene of another in a series of bloody car bombings intended to disrupt elections.

have less of a mandate. If the Sunni provinces won't vote for the national assembly, [assembly members] will have to bend over backwards to include Sunnis in the government."

Built into the transitional administrative law is a clause that could enable a group like the Sunnis to quash a new Iraqi constitution: Only two thirds of the people in as few as three provinces would have to vote no in a referendum to be held by October 15. If any one group dominates the parliament, it will have to work hard to build a public consensus—ostensibly, a fail-safe provision to ensure that no one is left out of the political process.

But the reality of Sunni inclusion might be limited to bringing in technocrats and intellectuals who would help write the constitution. Assuming Shiites sweep a majority of support, followed by a solid, if smaller, Kurdish block, it will be difficult to convince the Sunni street that their voices will be part of the national dialogue. Rather than let up, the shadowy insurgency, which has found sympathy and tacit support in Sunni communities, may try to harness the popular feeling of alienation. Says candidate Saad Abdulrazzak, a secular Sunni candidate who has aligned himself with onetime Washington favorite Adnan Pachachi: "If Sunnis are not represented in the next election, it will be a crack in Iraqi society, which will be very difficult to repair."

"It's amazing that it is coming together as it is."

CARLOS VALENZUELA, *United Nations elections adviser*

Already, signs of civil strife and sectarian provocation are emerging. The U.S.-led offensive on the insurgent stronghold of Fallujah in November, and the subsequent military operation in the city of Mosul, caused a ripple effect in Sunni communities. The Islamic Party denounced the legitimacy of the elections and declared a boycott, and the insurgency responded with a spike in politically motivated violence.

Then came suicide bombs on the steps of Shiite mosques and assassinations of Shiite politicians and sheiks. Influential Shiite leaders were quick to respond, advocating ballots over bullets, lest anything jeopardize their electoral ascendancy. Some imams went so far as to use their pulpits to warn potential voters that if they did not vote for the Shiite-dominated candidates' list 169, which boasts the unofficial blessing of the Grand Ayatollah Ali Sistani, they would have to answer to God. "The Shia are restraining themselves. They are holding their breath and not retaliating," says Adnan Ali, senior member of the Shiite-dominated Dawa party.

Election day. Making sure Iraqis would have a place to cast their ballots in a free and a fair environment has been a monumental challenge for the Iraqi Independent Electoral Commission, a government agency formed under the auspices of the United Nations. On election day, more than 5,000 polling centers throughout Iraq will be open until 5 p.m. to the estimated 14 million eligible voters. The

AFP / GETTY IMAGES

I am more than

my arms.

My back.

My sweat.

I am a fighter.

Mother.

Survivor.

Crusader.

I am one.

I am many.

I am America.

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threat of violence has curtailed the number of polling centers envisioned in places such as Mosul, where only 40 voting centers will be open in a city of 2 million people. Security has also kept away most international observers. Because of overseas ballots and security concerns, results are not expected until mid-February. "In a transitional election, by definition, the environment is not very conducive to credible elections," said Carlos Valenzuela, the U.N. technical adviser to the electoral commission. "It's amazing that it is coming together as it is."

Iraqis will face a national ballot with 111 political entities—independent candidates and lists formed by political parties—and seats in the national assembly will be awarded proportionately. In practice, most Iraqis will have no clear idea of which individuals they are voting for. Moqtada al-Sadr, the rebel street cleric, is rumored to hold a stake in the Sistani list, as is Ahmad Chalabi, a controversial figure who repositioned himself as pro-Shiite, anti-Baathist, and anti-American after falling out of favor in Washington.

Iraqi interim Prime Minister Ayad Allawi heads his own list and is waging a fierce campaign on satellite television, through slick, western-style advertisements and a miniseries, which characterizes him as a pro-democracy tough who once beat off ax-wielding assassins. More obscure groups, such as Chaldean and Assyrian minorities, are also making their voices heard, and a few candidates are vying for a seat by relying on established institutions, like the monarchy and the Communist Party, that may draw voters across ethnic and sectarian lines.

In such an atmosphere, it seems that democracy is there for the taking, not just for Sunnis, Shiites, and Kurds but also for Communists and monarchists. Says the self-proclaimed heir to the Iraqi throne, Sharif Ali bin Hussein, "The message should not be, 'You should vote.' The message should be, 'Your vote will count.'" ●

With Kevin Whitelaw in Washington

THE SHIITE FACTOR

Long vilified as extremists, these Muslims may hold the key to a new Middle East

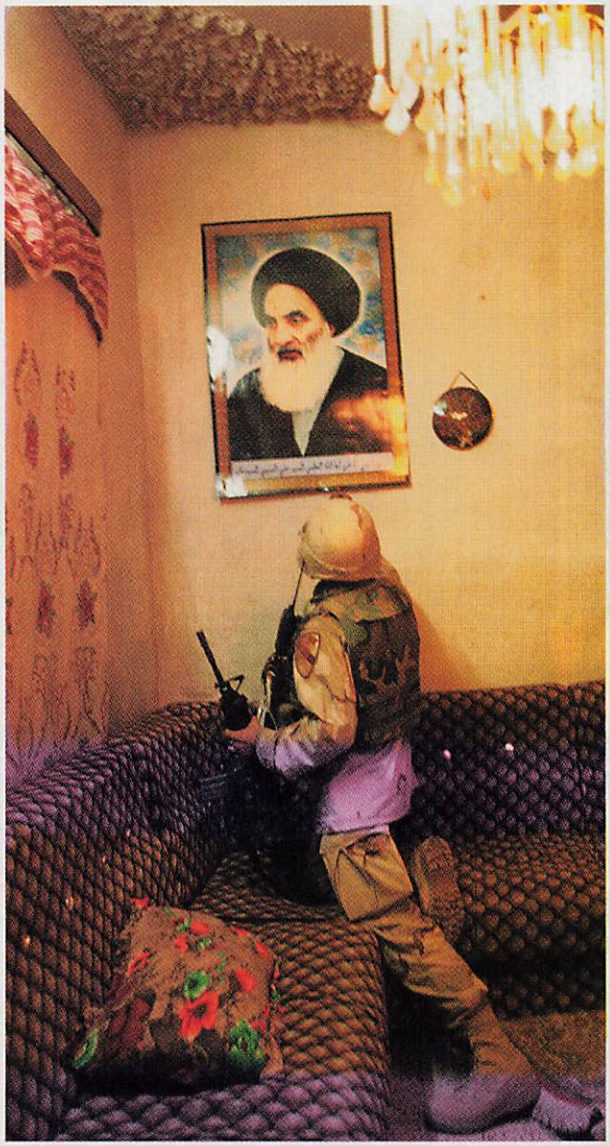
BY JAY TOLSON

Blunt words are not the usual fare of Washington think-tank gatherings. But American Enterprise Institute fellow Reuel Marc Gerecht served up a few at a recent roundtable discussion. "If Iraq fails," warned the former CIA analyst, "we're toast."

Even if many Americans might question the extremity of that forecast, most can at least understand some of the reasons behind it. Leaving Iraq in anarchy after the election would mean that the loss of American and Iraqi lives was largely pointless. A premature departure would also result in a further loss of U.S. prestige in the Middle East. What most Americans may not appreciate, however, is the vital importance of Iraq to the future of the Islamic world—and particularly to those internal sectarian and ideological struggles to define Islam and its role in states and societies. At stake, above all, is whether radical Islamist extremism of the al Qaeda variety will prevail over more progressive, tolerant interpretations and uses of the faith.

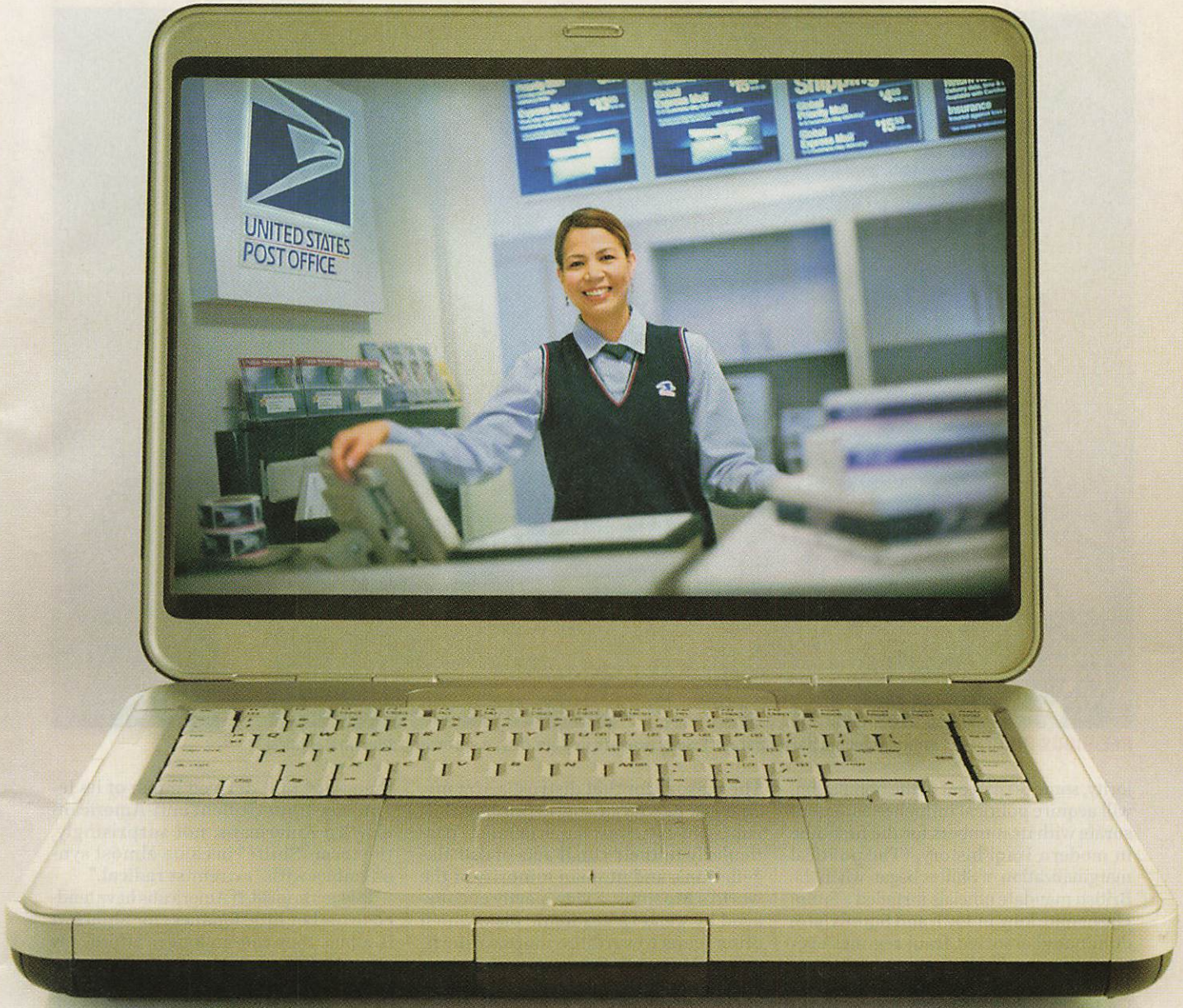
Long history. Surprisingly, no players may be more important to the outcome of those struggles than the Shiite Muslims of the Middle East. Belonging to a sect that constitutes roughly 10 to 15 percent of the world's Muslims, Shiites trace their origins to a succession fight for the caliphate in the early decades after the death of Mohammed. (They insisted that only kinsmen of the Prophet could be rightful caliphs; those who prevailed and became the vast majority of the world's Muslims, the Sunni, believed that caliphs need only come from the community of believers.) While the majority of Shiites live in Iran, Central Asia, and South Asia, those living in Saudi Arabia, Kuwait, and other parts of the Arab core of the Middle East (where Shiism originated) have often found themselves treated as second-class citizens—or worse—by their Sunni overlords, even in Bahrain and Iraq, where Shiites predominate.

Directly at issue in Iraq is not only the question of whether the nation's Shiite Muslim ma-



UNDER EXAMINATION. A U.S. soldier searches behind a portrait of Grand Ayatollah Ali Sistani in Sadr City, Baghdad.

STEPHANIE SINCLAIR—CORBIS



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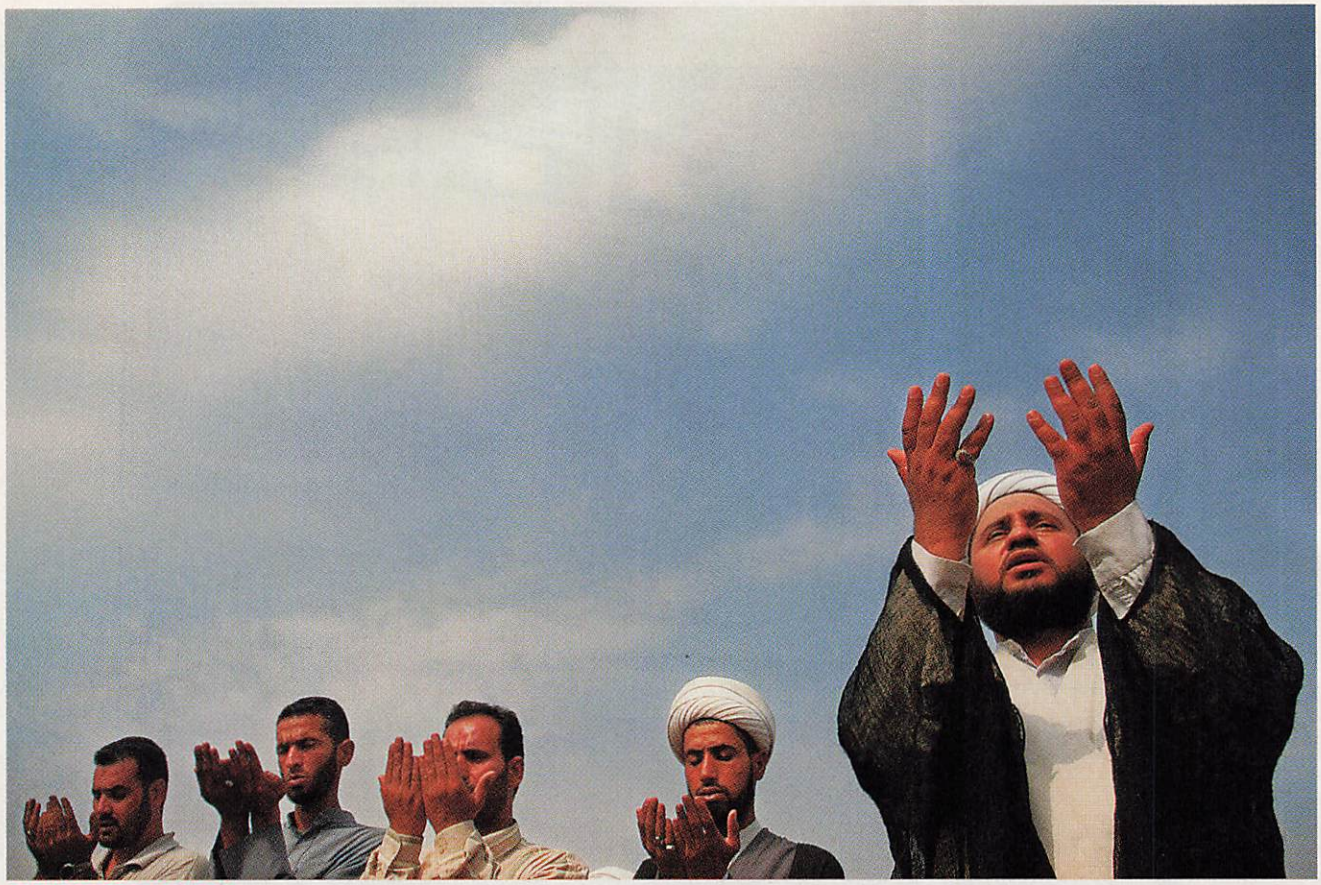


RELIGIOUS PRACTICE. Shiite Muslims participate in Friday prayers in Sadr City, a sprawling slum in Baghdad.

jority, some 60 percent of the population, will acquire political influence commensurate with its numbers for the first time in modern Iraqi history. (The political marginalization of Shiites began when the British mandate officials installed a Sunni Hashemite king in 1921, and Sunnis have dominated assorted Iraqi regimes ever since.) Just as important is whether the various Shiite movements, parties, and leaders—some more religious than others—will forgo triumphalism to support the creation of an inclusive democracy that is respectful of the rights of non-Shiites, Muslim or not. "Iraq can offer an alternative [to Islamist theocracies] if religion can be an influence on governance without being the political authority," says Nadeem Kazmi, head of international development at the London-based Al-Khoei Foundation, an Islamic charitable and development institute.

Because a favorable outcome in Iraq will depend largely on the Shiites, its achievement will be difficult unless Americans overcome an acquired uneasiness with the Shiite community. The reasons for that distrust are many. One is a partial misperception of Shiism as an extremist, emotionalist (particularly in their ritual acts of self-flagellation), and utopian minority of the world's Muslims, a view partly encouraged by western academic bias, which often leans toward the more western-oriented Sunni Ottomans and their heirs in modern Turkey. Another reason for U.S. wariness is rooted in a more practical political reflex inherited from European powers that once dominated large parts of the Muslim world: a predilection for working with Sunni Muslims while playing a game of divide-to-conquer with the Shiite and Sunni populations. Perhaps the greatest reason, though, is that Americans associate Shiism with the tumultuous Iranian Revolution of 1979, in which the Shiite cleric Ayatollah Ruhollah Khomeini installed a severe, repressive theocracy that derived much of its legitimacy from virulent anti-Americanism. To Americans, not surprisingly, the term "Shiite" became almost synonymous with "extremist radical."

"The United States [needs] to build bridges to... Shiites in the Arab world."

YITZHAK NAKASH, *historian and author of* The Shi'is of Iraq

Bridges to build. If Americans have tended to harbor little fondness for Shiites, it is a bias they can no longer afford, say Gerecht and other Middle East experts. Brandeis University historian Yitzhak Nakash, currently a fellow at Washington's Woodrow Wilson Center and author of *The Shi'is of Iraq*, put the challenge neatly in a recent presentation: "To contain the spread of Sunni radicalism, the United States will need to build bridges to those Shiites in the Arab world as well as to the reformers in Iran who have attempted to reconcile Islamic and western concepts of government."

Efforts to build such bridges were slow in coming in Iraq, even as a largely Sunni-led extremist insurgency grew in strength and lethality. While part of the U.S. administration for a time placed considerable stock in the Iraqi National Congress, led by Shiite businessman

ASHLEY GILBERTSON—AURORA

MODERNIZATION. Shiites enter holy scriptures into computers from original manuscripts in Qom, Iran.

Ahmed Chalabi, it initially neglected the religious leadership in the holy cities of Najaf and Karbala. That neglect came in part from failing to discriminate between the largely nonpolitical, "quietist" orientation of Iraq's religious establishment and the hyper-activist theocratic tendencies of Iran's ruling clerics. Unlike Khomeini's successors, Iraq's Grand Ayatollah Ali Sistani embraces a more traditional Shiite commitment to a separation of mosque and state, as long as the latter respects Islamic traditions and law (*sharia*). But even many U.S. Middle East experts did not fully appreciate Sistani's importance until after he defused tensions between U.S. forces and Moqtada al-Sadr by ordering the radical Shiite leader to vacate Najaf's Imam Ali Mosque.

A major cause of upheaval within the Islamic world is a crisis of religious authority, which developed, Al-Khoei's Kazmi explains, in tandem with a crisis of governance in modern predominantly Muslim states. To bolster their power, authoritarian rulers in Syria, Egypt, and elsewhere have variously suppressed restive religious leaders or cynically exploited more compliant ones. Not surprisingly, particularly within Sunni Islam, where lines of religious authority are relatively weak, self-made sheiks and mullahs have popped up all over the Middle East, proclaiming *fatwas* that justify even the most un-Islamic practices (including the killing of innocent civilians in the name of holy war).

"There are legitimate grounds for... greater hope [among Shiites]."

SAMI ZUBAIDA, *professor emeritus, Birkbeck College, University of London*

Tolerance. Amid this crisis of authority and governance, says Yusuf al-Khoei, a director of the Al-Khoei Foundation, the Shiites have many things to offer, including an appreciation for tolerance. Grandson of a Najaf grand ayatollah who died under Saddam-imposed house arrest in 1992 and nephew of cleric Abdul Majid al-Khoei, who was killed in Najaf in April 2003 shortly after returning to Iraq from England to work for peace in the newly liberated country, the soft-spoken man would have every reason to be embittered by decades of Sunni mistreatment of Shiites. But a key goal of the foundation he works for is cooperation and reconciliation with the Sunnis. "We have always maintained good relations with the Sunnis," Khoei says, "because we know in order for things to work in Iraq and throughout the world, we have to cooperate."

Al-Khoei is not alone in seeing the Shiites as a counterweight to intolerant Salafi Wahhabism, that narrow, literalistic, and increasingly widespread approach to the faith that declares all other interpretation of the sacred texts and all other sects, whether Shiism or mystical Sufism, as sinful innovations. Says Sami Zubaida, a professor emeritus of politics and sociology at the University of London's Birkbeck College, "By contrast with that [Salafist Islamist perspective], the Shia world is more hopeful and encouraging. It is more culturally complex—tolerating philosophy, mysticism, and other forms of learning. There are legitimate grounds for saying that

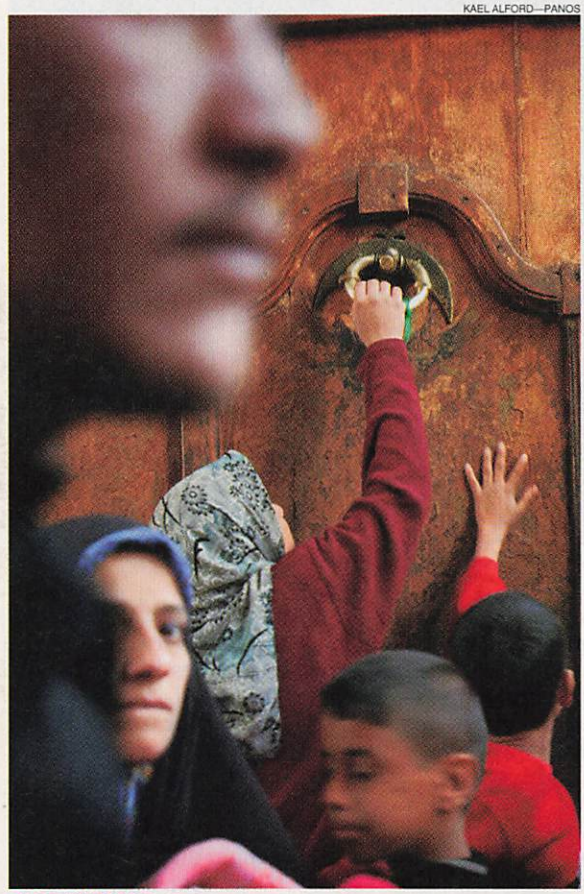
JEAN GAUMY—MAGNUM

there is greater hope for flexibility coming out of the Shiite world, where there is more nuance, complexity, and less fundamental antagonisms toward the West."

An important factor behind that flexibility is the fact that interpretation of the sacred texts remains open within Shiism, whereas within Sunni Islam the gates of interpretation (*ijtihad*) supposedly closed in the 10th century. Even Iran's Khomeini, for all his austerity, believed that the Koran had to be made relevant to the modern world. In addition to flexibility, Shiism suffers less from the general Islamic crisis of authority because it has unmistakable centers and figures of religious authority. Because there is widespread respect for Sistani—whose popular website makes his religious judgments available around the world—there is less chance that renegade mullahs such as Moqtada al-Sadr can ignore his rulings.

This is not to say that a Shiite-dominated political regime in Iraq will immediately satisfy all western notions of a modern, liberal democracy. And there will be debates— even within the broad Shiite coalition that Sistani has cobbled together—over how much Islamic law will shape the constitution and family and personal law. But there is strong evidence that Sistani is open to compromises. "He is particularly flexible," Nakash says, "and so are his most likely successors." Nakash goes on to elaborate that Sistani wants neither a theocracy nor a completely secular state: "We have to expect something that is neither the Iran of Khomeini nor the Turkey of Ataturk."

KAEL ALFORD—PANOS



OBSERVANCE. **Visitors touch the door as they leave the al-Khadim mosque, the largest Shia mosque in Baghdad.**

Tactics. Almost every supporter of a favorable outcome in Iraq agrees that America must be a careful midwife, exercising tact in diplomacy and greater shrewdness in its strategic thinking. Even being too cozy with Sistani might not be a good thing, particularly if he is perceived to be a U.S. lackey. And Iraq's chances of subduing the insurgency might be greatly helped, says Thomas Barnett, author of *The Pentagon's New Map: War and Peace in the Twenty-First Century* and a former professor at the U.S. Naval War College, if Washington tries to make Iran a more responsible player in the region. Tact means avoiding inflammatory labels such as "axis of evil" (which only rallies support for the shaky theocracy), and shrewdness means coming up with bargaining chips to draw Tehran away from building the Bomb. As he argues in a current *Esquire* article, Barnett believes that a more responsible Iran is more likely to change. "They will be influenced by what is happening in Iraq," he says. "Sistani may be their Lech Walesa."

Above all, urges Khoei, Washington should resist the colonialist habit of playing Shiites against Sunnis, Sunnis against Shiites, in Iraq and elsewhere. "Iraq is now the key," he says. "If the United States leaves a divided country, this will destroy America's image. People are wondering if America is dividing the Muslim world or uniting it. I hope it is using its influence to help unite it." •

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Since the product was first introduced, the following have been reported in patients using ENBREL:

- **Serious infections**
  - **Many occurred in people prone to infection, such as those with advanced or poorly controlled diabetes**
  - **Some serious infections were fatal**
  - **Rare cases of tuberculosis**
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If you have rheumatoid arthritis (RA), your vocabulary is about to change. Because for many, ENBREL has dramatically reduced the pain, stiffness, and fatigue of moderate to severe RA and can inhibit the progression of joint damage for 5 full years.* Envision your possibilities. Ask your rheumatologist about ENBREL, today.

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PORTRAIT: NORM COLEMAN

Ambitious crusader

BY TERENCE SAMUEL

It's hard not to notice Norm Coleman these days. The rise to prominence in Washington of the junior senator from Minnesota has been sharp and swift. He's close to the president. He's on trips to Southeast Asia with the majority leader, and last month, after only two years in the Senate, he made a nearly successful bid to chair the GOP Senate campaign committee in the new Congress, losing by a single vote. But it is his dogged pursuit of alleged corruption in the United Nations' former oil-for-food program in Iraq that has propelled Coleman into the public consciousness as Washington's chief tormentor of U.N. Secretary General Kofi Annan.

Coleman has called for Annan's resignation, and the senator is expected to announce shortly a new round of hearings into what he contends is a multibillion-dollar scheme of bribes and kickbacks. The program allowed Iraq to sell embargoed oil to buy food and medicine; a Security Council panel was supposed to ensure that the cash was not used to rearm Iraq. Coleman believes that the alleged fraud allowed Saddam Hussein to retain his grip on power and that the funds may now be available to the Iraqi insurgents. "I'd like to find out if this money is fueling the insurgency in Iraq and cut it off," he says. After one hearing last fall, Coleman estimated that more than $21 billion was siphoned from the program, most of it on Annan's watch. Critics challenge that number and accuse Coleman of grandstanding; recently released U.N. audits suggest the fraud might be on a smaller scale. But the senator is undeterred. "We fund 22 percent of the U.N. operating budget, so we have a stake in making sure that things we invest in are working efficiently. . . . I hope we can get to the bottom of it," says Coleman. But both admirers and detractors wonder whether Coleman's desire to get to the bottom of the U.N. allegations is just a vehicle to take him to the top.

Up the ladder. "He's very ambitious, and his recent actions really illustrate that," says Steven Schier, a professor of political science at Carleton College in Northfield, Minn. "I think you are going to see more of this, because I think this is a fellow who wants to run for the highest office you can find, and he's not going to stop."

A transplanted New Yorker who improbably served two terms as mayor of St. Paul, Minn., Coleman always seems to be in the middle of the action. He won one of the nastiest races of the 2002 campaign with 50 percent of the vote, defeating former Vice President Walter Mondale, who had stepped in as a Democratic standard-bearer after the incumbent senator, Paul Wellstone, was killed in a plane crash 11 days before the election.

From the very beginning, Coleman won admiration not just for his political skills and tenacity but for his resilience in the face of public setbacks and family tragedy. "He's a very talented politician," says Ron Ebensteiner, chairman of the Minnesota Republican Party. "What he was particularly good at was working across party lines, getting people of all parties, races, ethnicities going in the same direction."

But Coleman has inspired some detractors along the way. "He's the best self-promoter we've ever had to deal with in our state," says Michael Erlandson, chairman of the Minnesota Democratic-Farmer-Labor Party, or DFL, as the Democratic Party is known in Minnesota. "I think that his career shows that

JIM LO SCALZO FOR USN&WR

he is ambitious and opportunistic, that nothing is beyond the realm."

A partisan view, no doubt. But just how does a Jewish kid from Brooklyn who loved the Dodgers and led student protests in college, who served as Bill Clinton's state campaign cochair in 1996, end up as a conservative, antiabortion Republican senator from Minnesota with a Hollywood-actress wife? "God only knows," Coleman says, laughing. "I've been lucky. Doors have opened for me."

Antiwar protester. Some see a gatecrasher rather than a door opener. But either way, it's a story full of twists. Coleman grew up on Avenue O in Brooklyn, one of eight children in a Reform Jewish home, and attended the same high school as New York Sen. Chuck Schumer. After graduating from Long Island's Hofstra University in 1971, where he led protests against the Vietnam War, Coleman got a law degree at the University of Iowa in 1976 and went to work in the human-rights section of the Minnesota attorney general's office.

In 1981, he married actress and model Laurie Casserly, whose mother, Lois, was one of the early leaders of the antiabortion movement in Minnesota. The couple's first child, Adam, died within weeks of birth from a genetic condition known as Zellweger syndrome. Nine years later, their fourth child, Grace, just a few months old, succumbed to the same ailment. The couple has two other children, Jacob, 18, and Sarah, 15.

The family tragedies had a profound effect. By the time he made his first foray into politics, seeking the DFL endorsement for mayor of St. Paul in 1989, Coleman was solidly antiabortion. Losing two kids "certainly strengthened my resolve to value every life," he says, and allowed him to gain some perspective. "I know what the worst thing in the world is," he says. "Everything else is manageable."

He failed to get the DFL endorsement in 1989, but in 1993 he challenged the party's choice in the primary and won, and was elected mayor in November. Very quickly, he managed to offend a number of other DFL constituencies. He clashed with teachers over vouchers and with municipal unions over privatization. So even though he got credit for revitalizing St. Paul's downtown, bringing a National Hockey League franchise back to Minnesota, and improving the city's credit rating, he was on the outs with his party. He didn't sit still: In December 1996, Coleman switched parties and became a Republican. "I've always wanted to change things, and for some reason, my old party became the party defending big government and fighting against change in government," he says.

A year later, Coleman ran for governor against his old boss and patron Hubert Humphrey III, the DFL candidate, and beat him. But in a wild three-way race, both of them lost to a political neophyte named Jesse Ventura. So Coleman went back to his job as mayor of St. Paul and before long had picked up the U.S. Senate seat.

"He's quick to bounce back," Erlandson admits. Adds Schier: "What you're seeing from him now is an established pattern of behavior. It's not like he got to the Senate and we're saying, 'What happened to Norm Coleman?' Norm Coleman has always been aggressive. [He] has always been relentless."

Now, as chairman of the Permanent Subcommittee on Investigations, a panel of the Senate Homeland Security and Governmental Affairs Committee, Coleman and his oil-for-food investigation are attracting the attention of the world. The hearings are reminiscent of a time when chairmen of the fabled subcommittee used their powers to galvanize public outrage and catapult themselves into the spotlight. Then Sen. Harry Truman used the predecessor committee to shine a light on Pentagon waste during World War II, and Sen. Joseph McCarthy pursued his infamous anti-Communist investigations in the 1950s. Richard Nixon served on the committee, and Robert F. Kennedy was once its chief counsel.

Clearly, the subcommittee can be a powerful perch. So, is Coleman running for president? "No one in my position is going to answer that for you," Coleman says, directly sidestepping the question. He says he will seek re-election in 2008 and does not intend to run for president then. But, at 55, he notes pointedly, "I'm a young man." Point taken. ●

"Norm Coleman has always been aggressive. [He] has always been relentless."

Born: Aug. 17, 1949, Brooklyn, N.Y.

Family: Married to the former Laurie Casserly. Two children, Jacob, 18, and Sarah, 15.

Education: Hofstra Univ., B.A., 1971; Univ. of Iowa, J.D., 1976.

Public service: Minnesota attorney general's office, 1976–93; mayor, St. Paul, Minn., 1993–2001; U.S. senator, 2002–present; chairman, Senate Permanent Subcommittee on Investigations; member, Senate Foreign Relations Committee and Senate Agriculture, Nutrition, and Forestry Committee.

SPACE

EARTH'S DISTANT COUSIN

In what may be the strangest place in the solar system, some 'cosmic time travel' for science

BY CHARLES PETIT

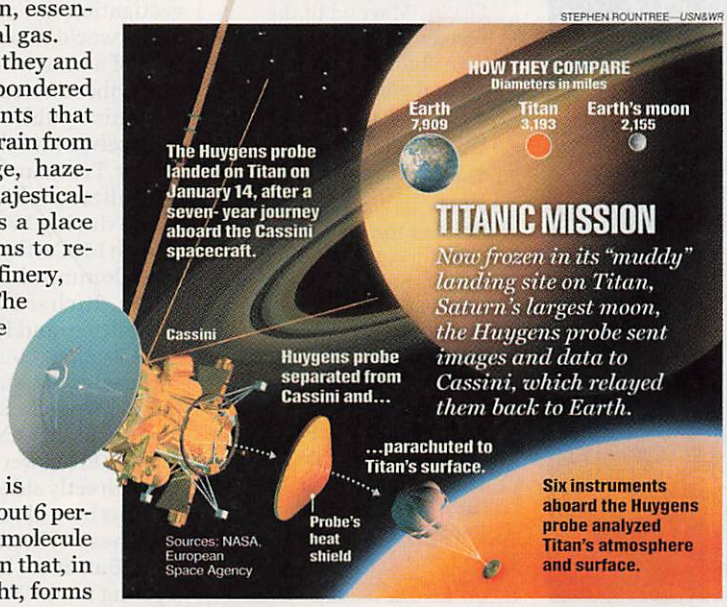
And the answer to a serious scientific question from the surface of the utterly weird and thoroughly smoggy, flammable, hydrocarbon-soaked Saturnian moon Titan is: thud. Or perhaps: splat.

And that's just fine with the international throng of planetary researchers who, on January 14 at a European Space Agency control room in Darmstadt, Germany, broke into giddy, relieved cheers. Telemetry from a tiny spacecraft named Huygens revealed it had survived the farthest landing any human machine has made on another world, whomping onto a soft but—surprising to some—not quite fluid surface soaked in, essentially, liquefied natural gas.

For nearly 30 years they and their colleagues have pondered in near disbelief hints that hydrocarbons literally rain from the sky on this large, haze-shrouded satellite of majestically ringed Saturn. It is a place whose chemistry seems to resemble that of an oil refinery, only far colder. The moon's reddish-orange atmosphere has half again the surface pressure of Earth's but at a bone-cracking minus 300 degrees Fahrenheit. It is mostly nitrogen and about 6 percent methane, a simple molecule of carbon and hydrogen that, in the presence of sunlight, forms more-complex hydrocarbons. By some calculations, nearly 2,000 feet of condensed ethane, acetylene, propane, methane, and more should have rained out over geological time as droplets and as solid, photochemical smog particles.

When we were very young. Titan excites scientists because it promises to tell a great deal about our own beginnings. Earth may have started with an atmosphere much like Titan's, which means that the moon's cold, stormy hydrocarbon cocktail offers a look back. Indeed, it and Earth are the only known orbs of any kind whose atmospheres are mostly nitrogen. "We have a very primitive environment here. We can do some cosmic time travel here," says Tobias Owen of the University of Hawaii.

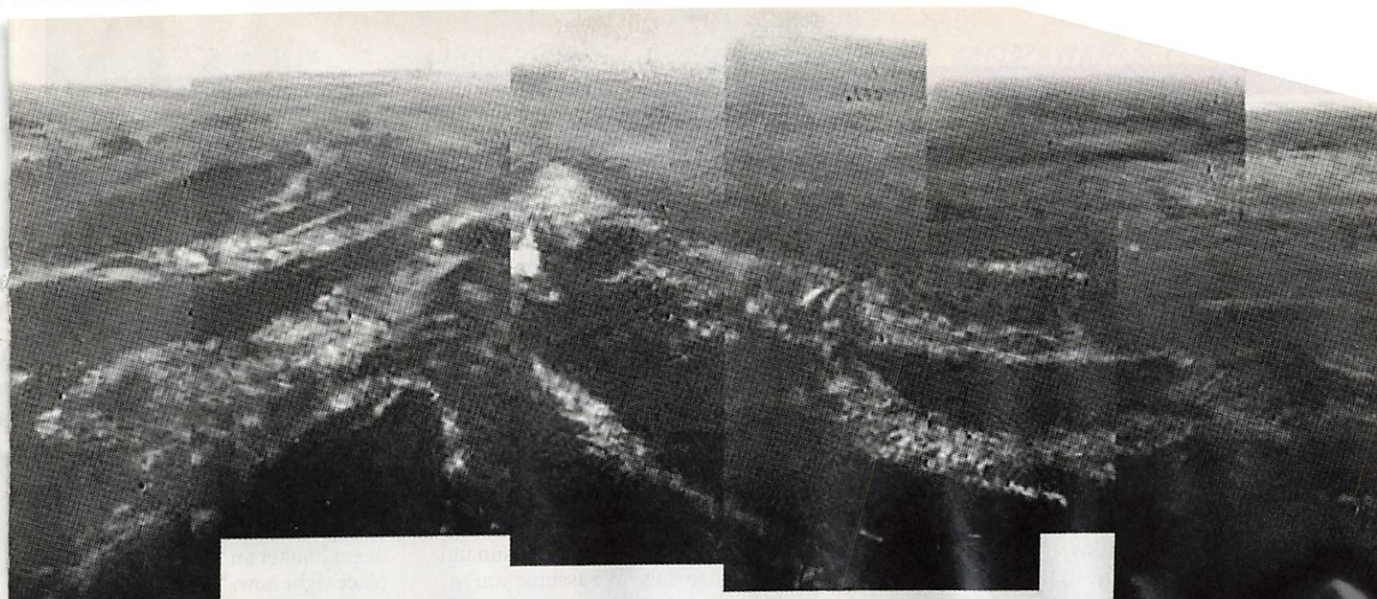
STEPHEN ROUNTREE—USN&WR



Already, it's been a long, strange trip. It took seven years and a 2.2 billion-mile trajectory for the Huygens craft to reach Saturn's environs. The disk-shaped, European-built probe headed for Titan on Christmas Day from its mother ship Cassini, a large, plutonium-powered NASA spacecraft that has been orbiting past Saturn's rings and among its moons since late last June. Three weeks later, it ripped into the moon's upper air at 12,400 miles per hour. Using three parachutes in sequence, it made a $2^1/_2$-hour descent, snapping pictures and measuring chemistry, wind, temperature, and pressure as it went.

A few hundred yards above the surface, a 20-watt spotlight switched on to give the probe's camera a boost in the dim and murky sunlight, about a thousandth as bright as at noon on Earth. It hit at about 11 miles per hour and then radioed data to Cassini, for relay to Earth, for an hour and 12 minutes more. The orbiter then moved below Huygens's horizon, but radio telescopes on Earth picked up data directly, faintly, for three hours more. (Mission managers had expected to hear from the landed Huygens for only half an hour, at most, before batteries died.)

Its impact deceleration pattern suggests the probe broke through a thin crust and settled a few inches into something like



VIEWS FROM ABOVE. A mosaic of images shows a 360-degree panorama around the Huygens probe. Below: the alien landscape. (The objects are roughly pebble-size.)

wet sand—most likely rock-hard grains of water ice in a methane broth. With its battery-heated interior at a balmy 77 degrees and its bright light just inches above the ground, the probe literally sizzled the soil.

During its trip down, Huygens's camera sent back a murky, Stygian panorama of intensely alien geography. A few pale-reddish highlands, almost certainly made of water ice, were laced with dark, branching gullies resembling earthly drainage channels. The uplands nestled against a nearly black plain, like a lakebed paved in asphalt. The dark material on the flats and in the riverbeds, researchers say, is probably eons' worth of smog particles that drifted to the ground and washed down from the icy high ground. Clouds of methane scudded low on the surface.

The site may lack the hypothesized hydrocarbon oceans, but the view relayed by its University of Arizona-managed descent camera confirmed that Titan often sloshes with liquid. The probe may have hit between storms. The ground was so wet with methane, says Huygens project scientist Jean-Pierre Lebreton, that it must recently have rained. "Suffice it to say this is a planetary scene like no other, vaguely disturbing and nightmarish to me and certainly not Mars or Venus," says Jonathon Lunine of the University of Arizona. He has calculated Titan's possible chemistry for decades and thinks open seas of methane may yet exist elsewhere on the moon. Martin Tomasko, chief scientist for the Arizona camera system, says, "The materials are different, but we see similar processes [on Earth]: precipitation, erosion, shorelines, and dry riverbeds." Some drainage patterns suggest that violent floods are common. The moon clearly remakes its surface constantly, for no meteor craters could be seen.

Weird science. "It is, by far, the strangest place in the solar system," says Bob Mitchell of NASA's Jet Propulsion Laboratory, where he is director of the international, $3.3 billion Cassini-Huygens mission to the rings and moons of Saturn. (The name comes from 17th-century Italian-French Jean Dominique Cassini, who first charted Saturn's rings, and his contemporary, Dutch astronomer Christiaan Huygens, discoverer of Titan.) The mission is to operate at least into 2008 and has already discovered three new moons, taking the total to 34 and counting. But the single most intriguing target all along has been the moon Titan, bigger than the plane Mercury and the only moon with a su stantial atmosphere. Titan's allure became fierce in 1980 when NASA's V ager spacecraft flew briefly confirming sketchy Earth-based vations that its thick atmosphere be a virtual petrochemical factory is nearly no oxygen—if it were p the moon's crust would explod

Chemistry similar to Titan astrobiologists who puzzle over of life in the universe, may be toward the evolution of li With no liquid water and r slowed by low temperatur likely did not go far down may offer parallels to pre

Within an hour or so as evidence m mordial petrol saturate Tita old-timer jok Cheney get though the lure the W for new d rocket u While th sible, Ti lash of al che send once Eart livin ove ha lar m h

ESA / NASA / UNIV. OF ARIZONA (2)

CLARINEX®
(desloratadine)
TABLETS, REDITABS® TABLETS

Brief Summary (For full Prescribing Information, see package insert.)

INDICATIONS AND USAGE: Allergic Rhinitis: CLARINEX Tablets 5 mg are indicated for the relief of the nasal and non-nasal symptoms of allergic rhinitis (seasonal and perennial) in patients 12 years of age and older.

Chronic Idiopathic Urticaria: CLARINEX Tablets are indicated for the symptomatic relief of pruritus, reduction in the number of hives, and size of hives, in patients with chronic idiopathic urticaria 12 years of age and older.

CONTRAINDICATIONS: CLARINEX Tablets 5 mg are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients, or to loratadine.

PRECAUTIONS: Carcinogenesis, Mutagenesis, Impairment of Fertility: The carcinogenic potential of desloratadine was assessed using loratadine studies. In an 18-month study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg/day in mice (estimated desloratadine and desloratadine metabolite exposures were approximately 3 times the AUC in humans at the recommended daily oral dose) and 25 mg/kg/day in rats (estimated desloratadine and desloratadine metabolite exposures were approximately 30 times the AUC in humans at the recommended daily oral dose). Male mice given 40 mg/kg/day loratadine had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg/day and in males and females given 25 mg/kg/day. The estimated desloratadine and desloratadine metabolite exposures of rats given 10 mg/kg of loratadine were approximately 7 times the AUC in humans at the recommended daily oral dose. The clinical significance of these findings during long-term use of desloratadine is not known.

In genotoxicity studies with desloratadine, there was no evidence of genotoxic potential in a reverse mutation assay (*Salmonella/E. coli* mammalian microsome bacterial mutagenicity assay) or in two assays for chromosomal aberrations (human peripheral blood lymphocyte clastogenicity assay and mouse bone marrow micronucleus assay).

There was no effect on female fertility in rats at desloratadine doses up to 24 mg/kg/day (estimated desloratadine and desloratadine metabolite exposures were approximately 130 times the AUC in humans at the recommended daily oral dose). A male specific decrease in fertility, demonstrated by reduced female conception rates, decreased sperm numbers and motility, and histopathologic testicular changes, occurred at oral desloratadine dose of 12 mg/kg in rats (estimated desloratadine exposures approximately 45 times the AUC in humans at the recommended daily oral dose). Desloratadine had no effect on fertility in rats at an oral dose of 3 mg/kg/day (estimated desloratadine and desloratadine metabolite exposures approximately 7 times the AUC in humans at the recommended daily oral dose).

Pregnancy C: Desloratadine was not teratogenic in rats at doses up to 48 mg/kg/day (estimated desloratadine and desloratadine metabolite exposures approximately 120 times the AUC in humans at the recommended daily oral dose). Desloratadine was not teratogenic in rabbits at doses of 9 mg/kg/day or greater (estimated desloratadine exposures approximately 50 times the AUC in humans at the recommended daily oral dose). Desloratadine was not teratogenic in pup development studies in pregnant rats at a dose of 3 mg/kg/day (estimated desloratadine metabolite exposures approximately 7 times the AUC in humans at the recommended daily oral dose). Desloratadine should be used in pregnancy only if clearly needed. The animal reproductive studies are not predictive of human reproductive risk, however, and should be used in pregnant women only if clearly needed.

Nursing Mothers: Desloratadine should be used with caution in nursing women. A decision should be made whether to discontinue nursing or to discontinue desloratadine, taking into account the importance of the drug to the mother.

Pediatric Use: The safety and effectiveness of CLARINEX Tablets in pediatric patients under 12 years of age have not been established.

Geriatric Use: Clinical studies of CLARINEX Tablets in pediatric patients and elderly subjects aged 65 and older. Other reported clinical experience did not include sufficient numbers of subjects to determine whether they respond differently from younger subjects. Other reported clinical experience or other drug therapy. (see **CLINICAL PHARMACOLOGY – Special Populations**). The elderly and young should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient

PHARMACOLOGY – Special Populations

Information for Patients: Patients should be advised not to exceed the dose or frequency of decreased hepatic, renal, or cardiac function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient should be cautious, but no differences between the elderly and young have been identified. Renal function, and dose selection for an elderly patient

directed. As there are no other drug therapy. (see **CLINICAL**

CLARINEX Tablets may be used to use CLARINEX Tablets as to increase the dose or frequency. Patients can be instructed that effectiveness at higher doses. Patients should be advised not RediTabs Tablets contain Phenylketonurics: CLARINEX

ADVERSE REACTIONS: Although not demonstrated increased patients received CLARINEX and placebo-controlled trials, 2,834 patients received the recommended daily, of whom 1,655 5 mg daily, the rate of adverse events was patients. The percent of patients receiving CLARINEX and placebo-treated 2.4% in the CLARINEX group were no serious adverse events in these trials in patients receiving desloratadine were reported by greater than or equal to 2% of patients receiving daily dose of CLARINEX Tablets (5.0 mg once-daily), are listed in CLARINEX Tablet than placebo, are listed in Table 5.

Table 5
Incidence of Adverse Events
of Allergic Rhinitis Patients in Placebo-Controlled

Adverse Experience	CLARINEX Tablets 5 mg (n=1,655)
Pharyngitis	4.1%
Dry Mouth	3.0%
Myalgia	2
Fatigue	
Somnolence	
Dysmenorrhea	

The frequency and magnitude were similar in CLARINEX and

There were no differences gender, age, or race.

Chronic Idiopathic Urticaria

idiopathic urticaria

Adverse events

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Schering
Kenilworth, NJ

Rev. 7/03
CLARINEX REDITABS brand of desloratadine orally-disintegrating tablets manufactured for Schering Corporation by Cardinal Health Limited, England.
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The Dobbs Report

LOU DOBBS

No more border games

PRESIDENT BUSH HAS AGAIN VOWED to spend his political capital to grant legal status to the millions of illegal aliens who live and work in this country. The president rationalizes his guest-worker program by constantly referring to the nation's need to match willing workers with willing employers. The president's "proposed reform" has already met stiff resistance from the 109th Congress, which is apparently ready to finally take on the critically important issue of illegal immigration. Many from the president's own party say they'll fight his guest-worker proposal, and many of our elected officials are finally grasping the importance of representing the views of working Americans—which, after all, is their responsibility. The latest *USA Today*/CNN/Gallup poll shows only 34 percent of those surveyed approve of President Bush's immigration policies. "The American people don't want open borders; they don't want amnesty," says Rep. Tom Tancredo, a Colorado Republican. "It's a message that is beginning to get through to the Congress. We've just got to get it through to the president." That message has gotten through to one of the administration's most cheerful and energetic loyalists on Capitol Hill, Rep. David Dreier of California. After ignoring the realities of illegal immigration for nearly all of his long tenure in Congress, Republican Dreier now says he will introduce legislation to stop American businesses from hiring illegal aliens, using a photo-embedded Social Security card, which employers would be required to check with a national database to determine whether a job applicant is legal or illegal. It's clear to me, just why [illegible] believes that any one of the [illegible] legal aliens who en- [illegible] last year, or the [illegible] who hire [illegible] turn law- [illegible] while we [illegible]

sure that we have control of our borders and ports, the Home land Security Department is simply a federal bureaucracy dulging in nothing less than a sham, spending billions of lars in taxpayer money to game the American people. shameless border games must end. And real reform mu That reform, in my opinion, begins at our borde what real reform should entail: No matter how mu manpower is required, we must be able to contr people and goods across our borders and through must exact heavy penalties on businesses, lar well as individuals who hire illegal aliens. N aliens cost the nations tens of billions of d ices, principally in healthcare and educat wages for American citizens by an estim American business is exploiting chea ly doing so with the blessing and su

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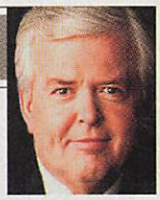


No more border games

PRESIDENT BUSH HAS AGAIN VOWED to spend his political capital to grant legal status to the millions of illegal aliens who live and work in this country. The president rationalizes his guest-worker program by constantly referring to the nation's need to match willing workers with willing employers. The president's "proposed reform" has already met stiff resistance from the 109th Congress, which is apparently ready to finally take on the critically important issue of illegal immigration.

Many from the president's own party say they'll fight his guest-worker proposal, and many of our elected officials are finally grasping the importance of representing the views of working Americans—which, after all, is their responsibility. The latest *USA Today*/CNN/Gallup poll shows only 34 percent of those surveyed approve of President Bush's immigration policies.

"The American people don't want open borders; they don't want amnesty," says Rep. Tom Tancredo, a Colorado Republican. "It's a message that is beginning to get through to the Congress. We've just got to get it through to the president."

That message has gotten through to one of the administration's most cheerful and energetic loyalists on Capitol Hill, Rep. David Dreier of California. After ignoring the realities of illegal immigration for nearly all of his long tenure in Congress, Republican Dreier now says he will introduce legislation to stop American businesses from hiring illegal aliens, using a photo-embedded Social Security card, which employers would be required to check with a national database to determine whether the job applicant is legal or illegal.

It is unclear to me just why Dreier believes that any one of the 3 million illegal aliens who entered this country last year, or the people in businesses who hire many of them, would turn law-abiding. At this point, while we should welcome Dreier's conversion, his proposal amounts to nothing more than a diversion from the profoundly important reforms that must be enacted. We must take control of our borders, enforce our immigration laws, and ultimately take responsibility for our first line of defense in the war on terrorism, specifically our borders and ports.

Until this administration and the federal government can ensure that we have control of our borders and ports, the Homeland Security Department is simply a federal bureaucracy indulging in nothing less than a sham, spending billions of dollars in taxpayer money to game the American people. These shameless border games must end. And real reform must begin.

That reform, in my opinion, begins at our borders. Here's what real reform should entail: No matter how much money or manpower is required, we must be able to control the flow of people and goods across our borders and through our ports. We must exact heavy penalties on businesses, large and small, as well as individuals who hire illegal aliens. Not only do illegal aliens cost the nations tens of billions of dollars in social services, principally in healthcare and education, but they depress wages for American citizens by an estimated $200 billion a year. American business is exploiting cheap labor and paradoxically doing so with the blessing and support of national unions.

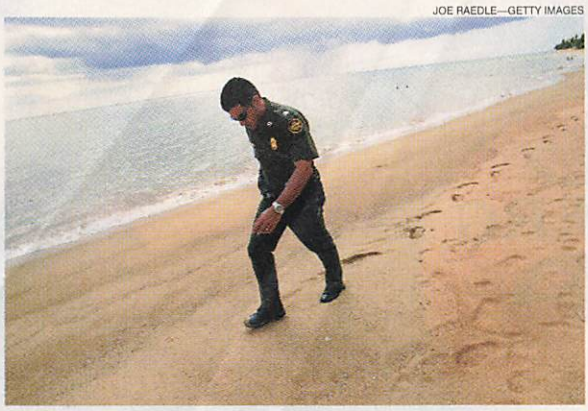
Skipping taxes. The burden of our failed immigration and homeland security policies, if they can be called policies, falls crushingly on working men and women in the form of higher taxes, lower wages, and an all but total lack of representation by the government they support through their votes and tax dollars. An estimated 6 million illegal aliens work in the underground economy, where neither they nor those who employ them pay taxes. That accounts for part of an additional $400 billion a year in taxes that should be paid to the Internal Revenue Service. Once again, the middle class is under assault by a government that is functioning as if it had never heard of the Declaration of Independence or the Constitution.

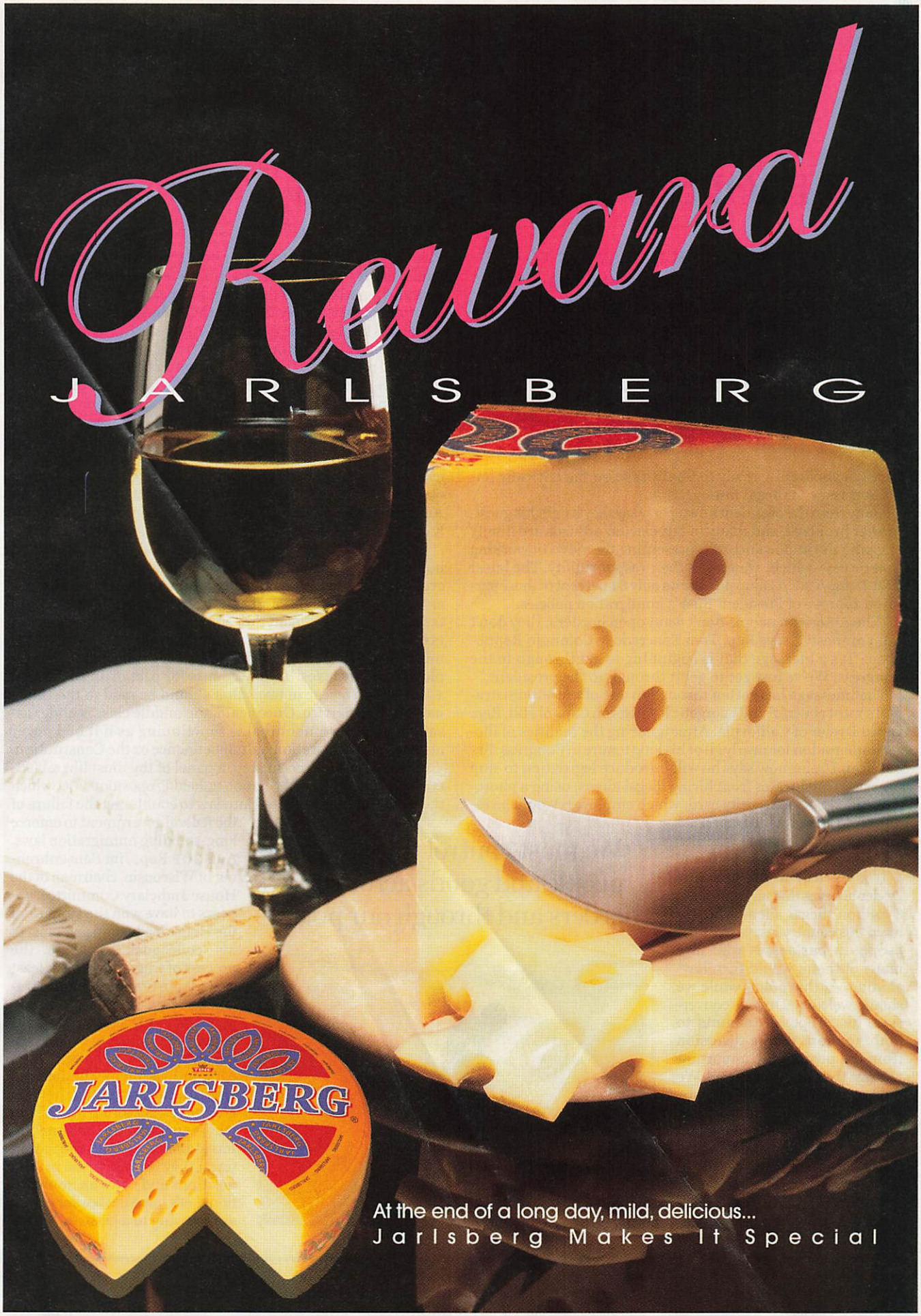
In an important recent step, a panel of the most liberal federal appellate court in the nation upheld Proposition 200, which the people of Arizona voted into law to counteract the failure of the federal government to enforce long-standing immigration laws. And GOP Rep. Jim Sensenbrenner of Wisconsin, chairman of the House Judiciary Committee, appears to have won the support of the House leadership and most of his colleagues to begin the process of true reform on at least a small portion of our immigration policies.

But if the Dreier proposal is given precedence over Sensenbrenner's, we will have a clear, early indication of whether this House, and eventually the Senate, have mustered the will to truly represent the national interest instead of the special interest they've long served in their positions and votes on immigration. Let's hope the border games are drawing to a close. ●

> We must control the flow of people and goods across our borders and through our ports.

JOE RAEDLE—GETTY IMAGES

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LETTER FROM THAILAND

A sea change in paradise

BY BAY FANG

PHUKET—In a poolside pavilion that usually houses a Thai restaurant, Buddhist monks in saffron robes sit in a row, chanting prayers. Before them kneel the staff of the Amanpuri, one of Thailand's most exclusive hotels. Tall palm trees sway in the breeze behind them, and blue-green waves lap at the pristine shore below—a welcoming sea that turned so deadly one December morning. The monks have come to perform a traditional "merit making" ceremony. "We need closure," says Frederic Varnier, the general manager. "One way to move on is to pray to the gods and spirits, to move on to better things."

For all is not right in paradise. At a time of year when the hotel is usually thronged with well-heeled travelers, there is only one couple sunbathing by the pool. The white-sand beaches are abandoned, the restaurants empty. The staff is being encouraged to eat the prime Wagyu steak imported from Australia because the refrigerators are overstocked for what was supposed to be high season. "We went from working 10-hour days to nothing, right about on January 3," says David Menhennett, a personal trainer working with the Amanpuri.

Double whammy. Phuket long has been one of the most desired tourist destinations in Asia, for everyone from backpackers prowling Patong's neon-lit bars to jet-setters shelling out thousands of dollars a night to stay at one of Amanpuri's ocean-view villas. But since the December 26 tsunami, nonstop television coverage of death and destruction in the region, as well as fear of disease, has kept tourists away—and that is taking a second toll on the island.

Tourism revenue here is expected to plunge by about $1 billion this year, or about 40 percent. Debbie Dionysius, director of Destination Marketing for Laguna Phuket, which operates five properties on the island, including the exclusive Banyan Tree resort, says that only 44 rooms out of a total of 1,100 were damaged by the tsunami. While the properties normally average 90 percent occupancy in January, this month averaged just 15 percent. "We're looking at close to $7 million in losses," she says. "Cancellations are slowing down now, but that's because there's nothing left to cancel."

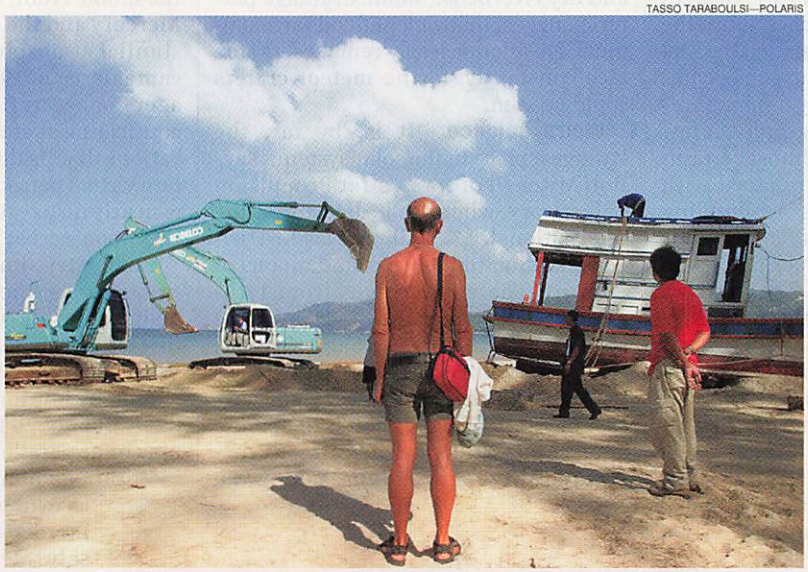
Richard and Penny Ballard of London say the only reason they kept their reservation at Amanpuri was that they had booked directly with the hotel. When they wrote an E-mail after the tsunami saying, "We assume you're closed," they got an immediate reply assuring them that the hotel was operating normally, with the exception of some gym equipment that had been swept away. Today, they lie on deck chairs on the empty beach, sip champagne, and say that if they didn't know better, there would be no way to tell a disaster had hit here a month ago. "We thought of people suffering bereavement, and not wanting to interfere with that. We wondered if the other passengers on our plane were coming to look for missing relatives," says Richard Ballard. "But the hotel told us that what was needed was for people to keep coming."

The immediate future does not look much brighter. Though some hotels are pinning their hopes on tourists in the region coming during the Chinese New Year period in early February, others think Asians will be deterred by superstitions that would deem Phuket an "unlucky" place right now. "Hong Kong tour companies have basically wiped Phuket off the face of the map," says Dionysius, noting that Hong Kong is usually a strong market for the island. "I don't think people would have come anyway, though."

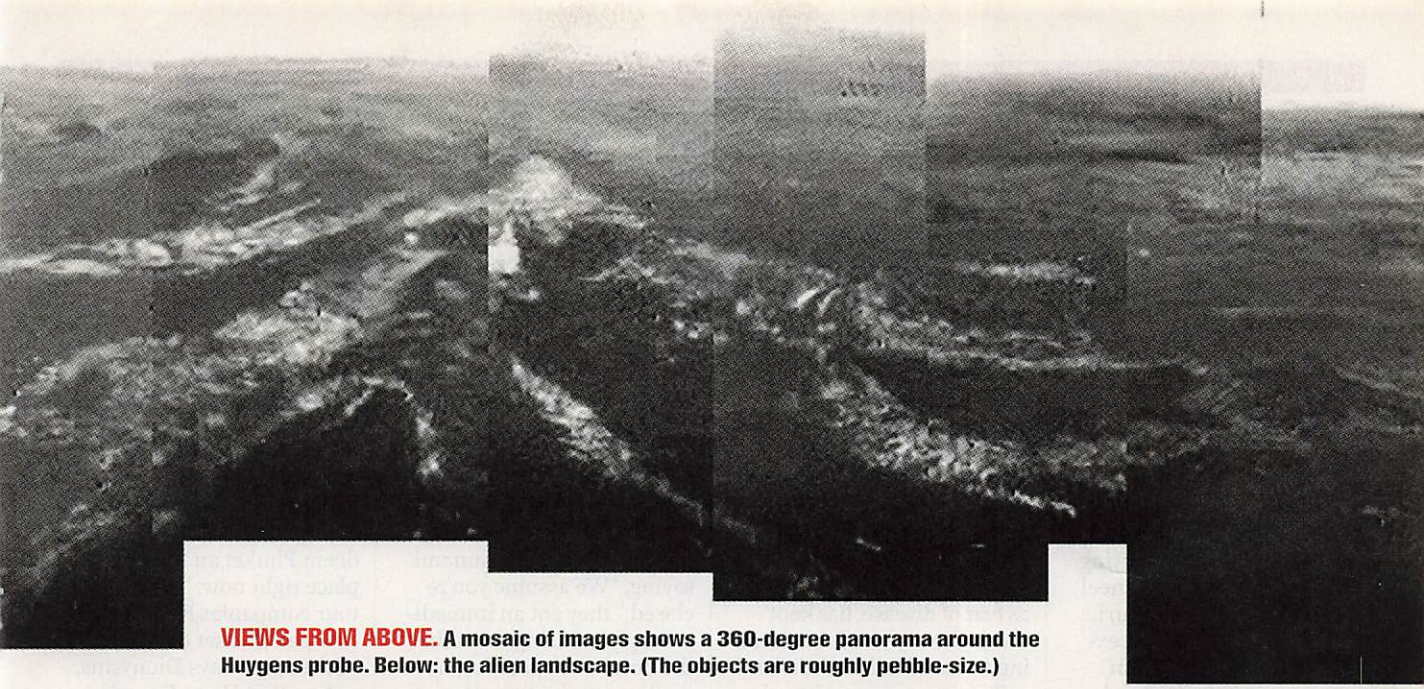
If this persists, an entire economy dependent on the tourism industry will suffer another round of loss. Already, talk around town is all about who has just lost a job and who expects to be next. At Amanpuri, though the permanent staff remains, part-timers have all been laid off. Thailand's tourism authority estimates that a quarter of the 100,000 tourism workers in the Phuket area have lost their jobs.

To counter this, hotels are putting together packages to attract guests, lowering rates, and launching extensive marketing campaigns. Some resorts have teamed up with Thai Airways to bring in travel agents to show them firsthand that the island is ready for business. "At first we didn't want to be too aggressive, because the island was going through a mourning period," says Dionysius. "But now, we have to get moving."

TASSO TARABOULSI—POLARIS



ON THE BEACH. A tourist watches tsunami cleanup work on Phuket island.



VIEWS FROM ABOVE. **A mosaic of images shows a 360-degree panorama around the Huygens probe. Below: the alien landscape. (The objects are roughly pebble-size.)**

wet sand—most likely rock-hard grains of water ice in a methane broth. With its battery-heated interior at a balmy 77 degrees and its bright light just inches above the ground, the probe literally sizzled the soil.

During its trip down, Huygens's camera sent back a murky, Stygian panorama of intensely alien geography. A few pale-reddish highlands, almost certainly made of water ice, were laced with dark, branching gullies resembling earthly drainage channels. The uplands nestled against a nearly black plain, like a lakebed paved in asphalt. The dark material on the flats and in the riverbeds, researchers say, is probably eons' worth of smog particles that drifted to the ground and washed down from the icy high ground. Clouds of methane scudded low on the surface.

The site may lack the hypothesized hydrocarbon oceans, but the view relayed by its University of Arizona-managed descent camera confirmed that Titan often sloshes with liquid. The probe may have hit between storms. The ground was so wet with methane, says Huygens project scientist Jean-Pierre Lebreton, that it must recently have rained. "Suffice it to say this is a planetary scene like no other, vaguely disturbing and nightmarish to me and certainly not Mars or Venus," says Jonathon Lunine of the University of Arizona. He has calculated Titan's possible chemistry for decades and thinks open seas of methane may yet exist elsewhere on the moon. Martin Tomasko, chief scientist for the Arizona camera system, says, "The materials are different, but we see similar processes [on Earth]: precipitation, erosion, shorelines, and dry riverbeds." Some drainage patterns suggest that violent floods are common. The moon clearly remakes its surface constantly, for no meteor craters could be seen.

Weird science. "It is, by far, the strangest place in the solar system," says Bob Mitchell of NASA's Jet Propulsion Laboratory, where he is director of the international, $3.3 billion Cassini-Huygens mission to the rings and moons of Saturn. (The name comes from 17th-century Italian-French Jean Dominique Cassini, who first charted Saturn's rings, and his contemporary, Dutch astronomer Christiaan Huygens, discoverer of Titan.) The mission is to operate at least into 2008 and has already discovered three new moons, taking the total to 34 and counting. But the single most intriguing target all along has been the moon Titan, bigger than the planet Mercury and the only moon with a substantial atmosphere. Titan's allure became fierce in 1980 when NASA's Voyager spacecraft flew briefly past, confirming sketchy Earth-based observations that its thick atmosphere should be a virtual petrochemical factory. There is nearly no oxygen—if it were plentiful, the moon's crust would explode.

Chemistry similar to Titan's, say astrobiologists who puzzle over the origin of life in the universe, may be a first step toward the evolution of living things. With no liquid water and reaction rates slowed by low temperature, Titan most likely did not go far down that path but may offer parallels to prebiotic Earth.

Within an hour or so of the landing, as evidence mounted that primordial petroleum does indeed saturate Titan's crust, a NASA old-timer joked, "Wait till Dick Cheney gets wind of this!" as though the far-off moon could lure the White House's hunger for new oil fields, lighting a rocket under the space budget. While that is of course impossible, Titan's hydrocarbon goulash offers clues to how natural chemical processes might send evolution on its way. Earth's buried swamps of once living matter, pressure-cooked over eons in sedimentary rock, have left a trove of very similar stuff. An individual's fate may be dust to dust, but perhaps the trajectory of life is better described as methane to methane. ●

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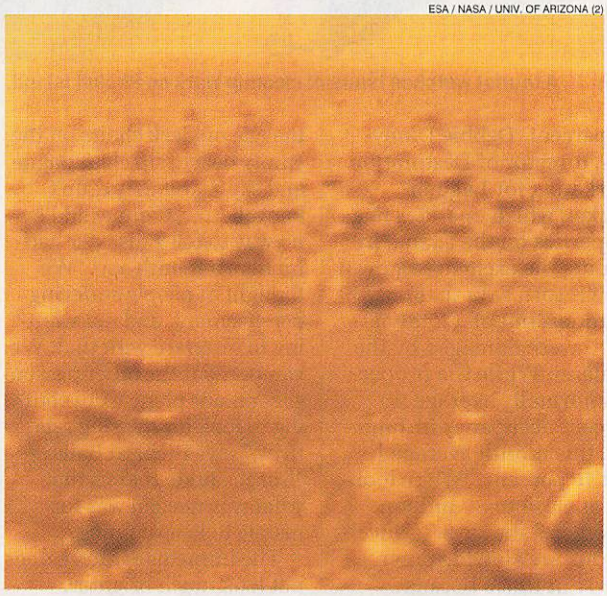
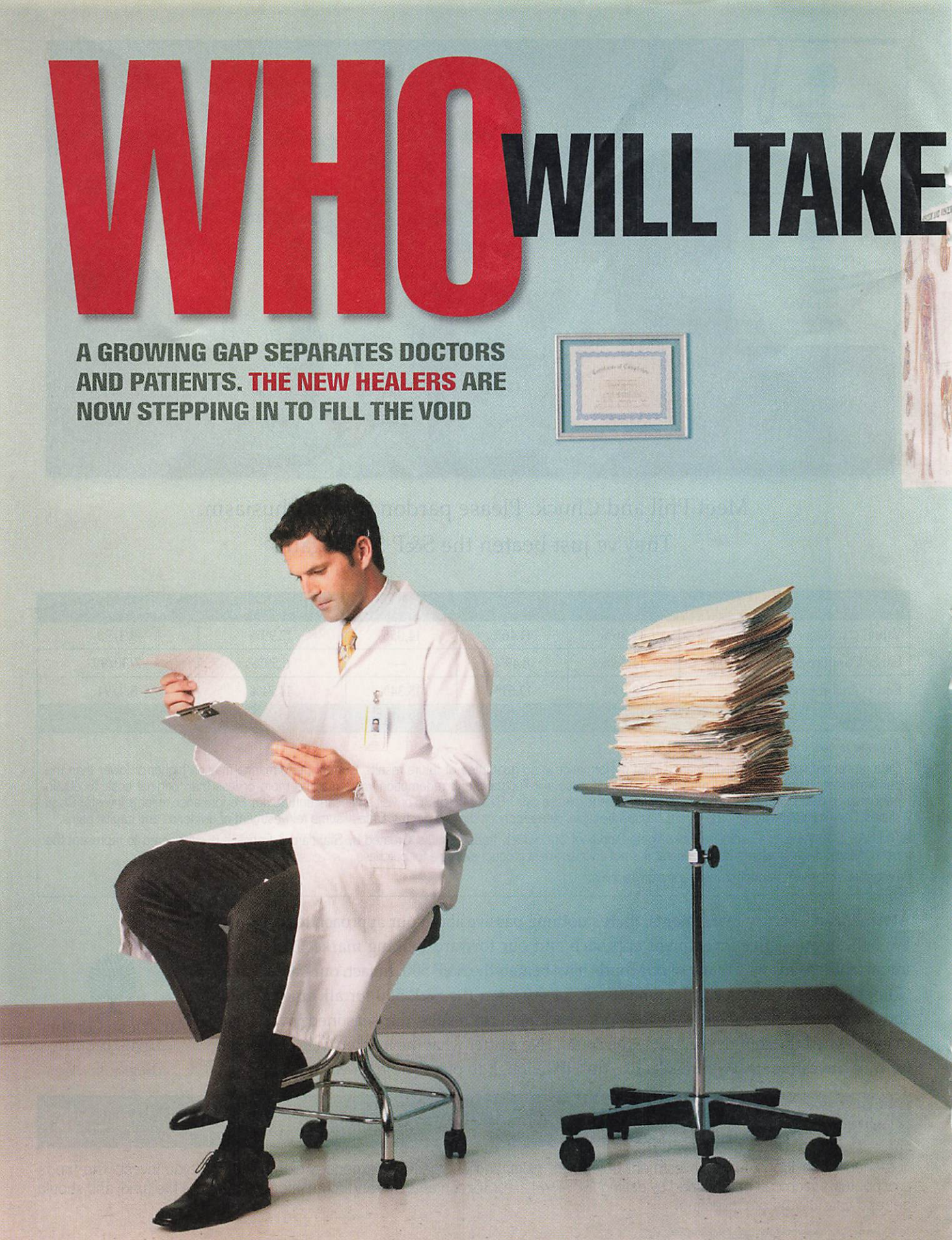


WHO WILL TAKE

A GROWING GAP SEPARATES DOCTORS AND PATIENTS. THE NEW HEALERS ARE NOW STEPPING IN TO FILL THE VOID



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S&P 500	10.88%	-2.30%	12.07%	—	—

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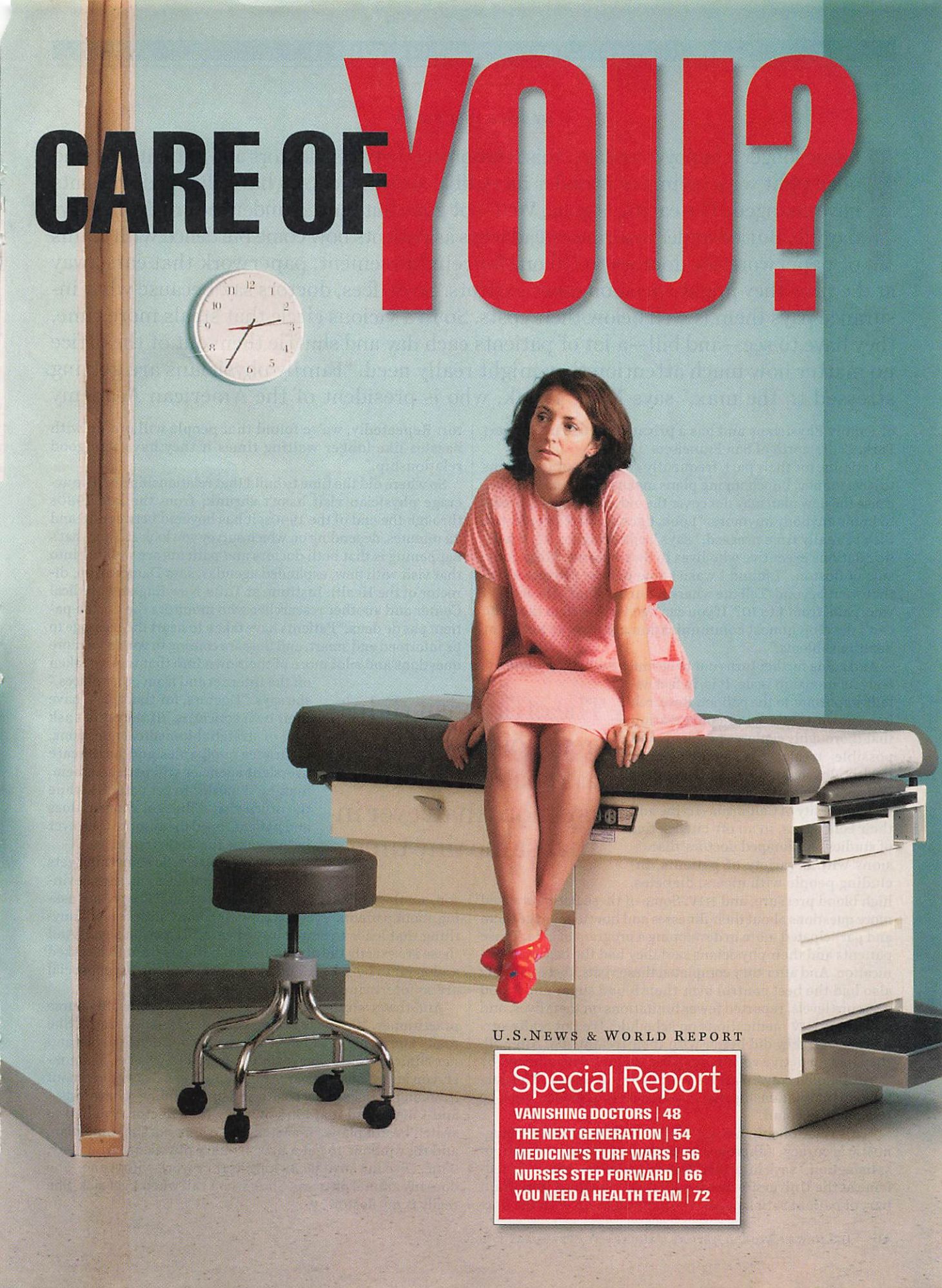

U.S.NEWS & WORLD REPORT

Special Report

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BY JOSH FISCHMAN

It is no longer a happy marriage, this relationship between doctors and patients. A bond once tight with intimacy is under incredible strain. Doctors have changed. Patients have changed. The caring is gone. Well, not gone but buried under the crush of everyday life. Buried under insurance headaches as patients now come burdened with reams of paperwork for doctors to fill out for reimbursement, paperwork that eats away at the time they might spend on other patients. So do fees, doctors say, because what insurance pays them is well below their costs. So in a vicious circle that steals more time, they have to see—and bill—a lot of patients each day and shuffle them out of the office no matter how much attention they might really need. "Family physicians are getting stressed to the max," says Mary Frank, who is president of the American Academy of Family Physicians and has a private practice in Rohnert Park, Calif., north of San Francisco.

Patients, for their part, frequently switch insurance plans to save money, but changing plans means changing care, because the new plan may not cover the old doctor. Nobody gets to know anybody anymore. "Look, docs are nice people, but they're really time pressed," says Todd Ringler, 37, a public relations executive who lives in Swampscott, Mass., outside of Boston. "I found I wasn't able to have conversations that went beyond 'Tell me where it hurts. What's the level of your pain, from 1 to 10?' If you can't go further than that, you can't develop honest communication about your health or health problems."

And going further turns out to be much more than a touchy-feely relationship issue. It is, in fact, vitally important to the patient. Research has shown that a good conversation that thoroughly explores problems and possible treatments means better health. Physician Sheldon Greenfield and social scientist Sherrie Kaplan of the University of California–Irvine and their colleagues, in an oft-cited series of studies, audiotaped doctors' discussions with a variety of patients, including people with ulcers, diabetes, high blood pressure, and HIV. Some of these patients asked more questions about their illnesses and how to manage them and participated more in developing a program of care. These patients and their physicians said they had the best communication. And after they completed these visits, these patients also had the best control over their blood sugar and blood pressure levels, reported fewer limitations on their lives, and took their HIV medications on schedule. It's not really surprising that they did better with their treatments. After all, they had an active role in devising them, a role allowed by these detailed conversations with their physicians. The doctor-patient relationship, the researchers concluded, "must be taken into account."

"This relationship has clearly been shown to affect diagnostic accuracy, adherence to treatment plans, and patient satisfaction," says internist Wendy Levinson, chair of medicine at the University of Toronto. "And the most important part of patient satisfaction is communication with the doctor. Repeatedly, we've found that people will put up with hassles like longer waiting times if they have this good relationship."

So where did the time to build that relationship go? The average physician visit hasn't shrunk; from the late 1980s through the end of the 1990s, it has hovered between 16 and 22 minutes, depending on which survey you look at. But what's happening is that both doctors and patients are walking into that visit with new, expanded agendas, says Dana Safran, director of the Health Institute at Tufts-New England Medical Center and another researcher who monitors the doctor-patient pas de deux. "Patients have taken to heart the message to be informed and smart, and they are coming in with a lot more questions and a lot more of their own info that they've taken off the Internet and from other places," she says. "Doctors, for their part, have their own concerns." If they don't ask a lot of straight biomedical questions, insurance companies and healthcare oversight agencies will penalize them, making it harder to get paid. So while the office visit didn't get shorter, docs and patients need to say more than ever in that same tiny time frame.

> The office visit didn't get shorter. But docs and patients need to say more than ever in that same tiny time.

Psychosocial ties. So something gets cut out. And what docs cut, says Levinson, are the psychosocial aspects of the visit. "They're not asking about patients' lives, about their communities, about anything that leads to continuity of care," Levinson says. "And these are exactly the questions that patients want to be asked and need to be asked. The biomedical and the psychosocial are so intertwined in primary care."

And that's why Todd Ringler sees Anne Krekis, his nurse practitioner. "I've been seeing her since 1992," he says. "She really knows me, and I have complete confidence in her and her clinical ability. For instance, I used to be a social smoker, you know, out in a bar. Anne and I had a discussion about it, about the risks to my health and to my family—I have kids—and I never had that kind of talk with a doctor. I've had to switch health plans, or switch care centers in the same plan, and they tell me to get a new primary physician. And I say, 'Fine. Give me anyone. As long as they work with Anne.' She does my annual physical. She's who I call when I get sick. She really is my doctor." •

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Doctors Vanish From View

HARRIED BY THE BUREAUCRACY OF MEDICINE, PHYSICIANS ARE PULLING BACK FROM PATIENT CARE

BY KATHERINE HOBSON

"It was slow water torture," says Paul Ryack. That's how the 63-year-old board-certified internist describes his working life just a few years ago. With a few thousand patients, many of them elderly, he could barely find time to listen to halting explanations of their immediate complaints—let alone talk about the importance of lowering blood pressure or losing weight—in the 15 or so minutes he could allot to each. "I was unable to make the time to sit with patients, to get to know them, to help with preventive activities that we need and want," says Ryack, who practices in Santa Barbara, Calif. His costs were so high, and payment per patient so low, that taking even another dozen minutes wasn't possible. "You'd go broke," he says. The end result: a creeping sense of burnout.

Many doctors around the country are similarly frustrated. A 2001 California survey of physicians found that 75 percent of respondents grew less satisfied with practicing medicine over the previous five years. A nationwide survey by the Henry J. Kaiser Family Foundation found that 87 percent of doctors say the overall morale of the profession has gone down in the past few years, and nearly 60 percent said their own morale had declined.

Chat with your own doctor—on the off chance she has time for a conversation—and she is likely to echo those sentiments. "The practice of medicine does not offer the kinds of rewards for what you have to put into it," says Carl Getto, associate dean for hospital affairs at the University of Wisconsin Medical School, who oversees a staff of more than 1,000 physicians.

The hassle factors. Those rewards—including satisfying relationships with patients, autonomy, high status, and comparatively high pay—are increasingly outweighed by the reality of a 21st-century U.S. medical practice. In their place: reams of time-consuming paperwork that is out of proportion to time spent caring for patients, declining reimbursements from insurers, a loss of autonomy from managed care, and fear of malpractice lawsuits.

For patients, the implications of these changes are huge. Some doctors are retiring or cutting back their hours. That means fewer doctors are available. Others are opting for specialties, such as radiology, with less demanding schedules. Many are cutting out certain insurers, and thus cutting out patients who use those insurers. A handful are deliberately restructuring their prac-

LIFE CHOICES Pediatrician Jennifer Shu works hard caring for babies. But she also feels that it's crucial to set limits on her job and give time to her own family.

JASON GROW FOR USN&WR

tices to see fewer—and richer—patients. "It's like a casino," says Doug Farrago, a family medicine physician in Auburn, Maine, and publisher of *Placebo Journal*, a publication filled with the dark ironies of current medicine. "Older docs can cash in their chips, and younger ones are looking for a different game," he says. In a country that will demand more and more from its healthcare system as the population ages, this is only going to get worse—and your doctor's problems may become yours.

It's not surprising that the doctors who are most upset about how things are now are the 50- and 60-year-olds who remember how it used to be: You made medicine your top priority and reaped emotional and financial rewards. "It was the golden age of medicine when they came in—it was fee for service, and you did what you thought was the best thing for the patient," says Phil Miller with Merritt, Hawkins & Associates, an Irving, Texas-based physician search firm. But the rise of managed care and large insurers, for better or for worse, has changed things. Insurance companies may not cover the drug a doctor prefers to prescribe for a given condition. Mountains of paperwork are required to gain approval for consults or outside services. Then there is the threat of malpractice suits. Doctors in so-called crisis states have stopped delivering babies or staged walkouts in the face of climbing insurance rates; even where insurance is more affordable, doctors fear being sued. That takes a toll.

So does the ever ticking clock. Insurers, doctors say, keep reimbursements so low that it's not economically possible for a primary-care doctor to practice with fewer than a few thousand patients on the rolls. That's where the squeeze comes in—the average 17-minute office visit may not be sufficient to get enough information to diagnose the problem and talk about the ever growing list of health issues they're supposed to bring up, from screening for skin cancer to advocating exercise and a healthful diet to being alert to signs of domestic abuse or addiction. That doesn't even count time to answer patients' questions about drug ads they've seen or information they've researched on the Internet. "The average doctor sees 25 people a day," says Rachel Naomi Remen, cofounder of the Commonweal Cancer Help Program and a family and community medicine professor at the University of California–San Francisco (story, page 51). "I don't know how to say hello to 25 people a day."

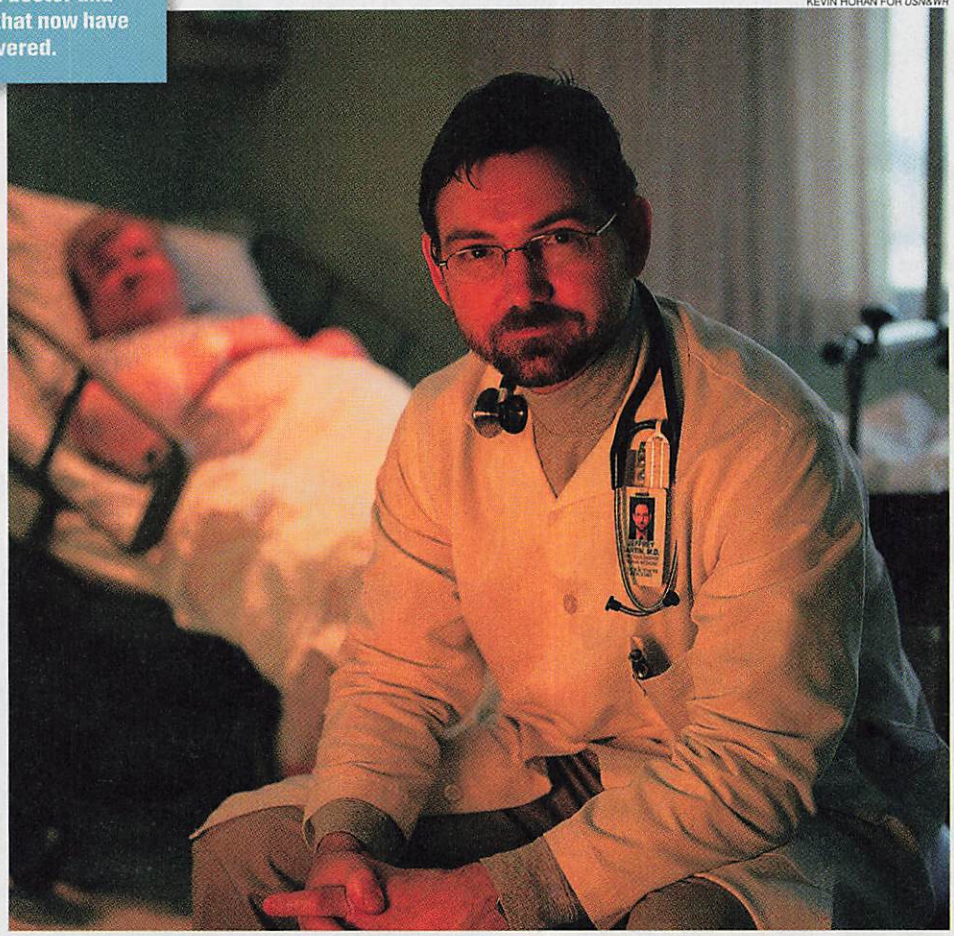
None of these problems are going away, because the dismay of the elders has now trickled down to newly minted healers.

A matter of time. Worse, those meager 17 minutes may be with a different doctor every few years, because when employers switch insurers, or people change jobs, their old doc often isn't part of the new plan. That's a real loss. When you aren't familiar with a patient's past care, it becomes difficult to track, monitor, and anticipate the medical needs.

Patients in turn feel less connected to doctors whose names they may not even remember; that contributes to eroded respect. "My father had a lot of health problems and was taken care of by a gentleman who was fairly old at the time," recalls Jeffrey Sartin, a 43-year-old infectious disease specialist in La Crosse, Wis. "My dad regarded Dr. Murphy as only slightly below God, and that awe and respect . . . is something I learned at a very early age. That has definitely changed. Not only are doctors not accorded respect, people are waiting to throw brickbats at them."

Sartin hastens to add that he doesn't want to return to the paternalistic days when patients were so in awe of doctors that they accepted their decisions, no questions asked. But some doctors are frustrated that while they have less sway with patients to comply with treatment, they have more expectations heaped on

KEVIN HORAN FOR *USN&WR*



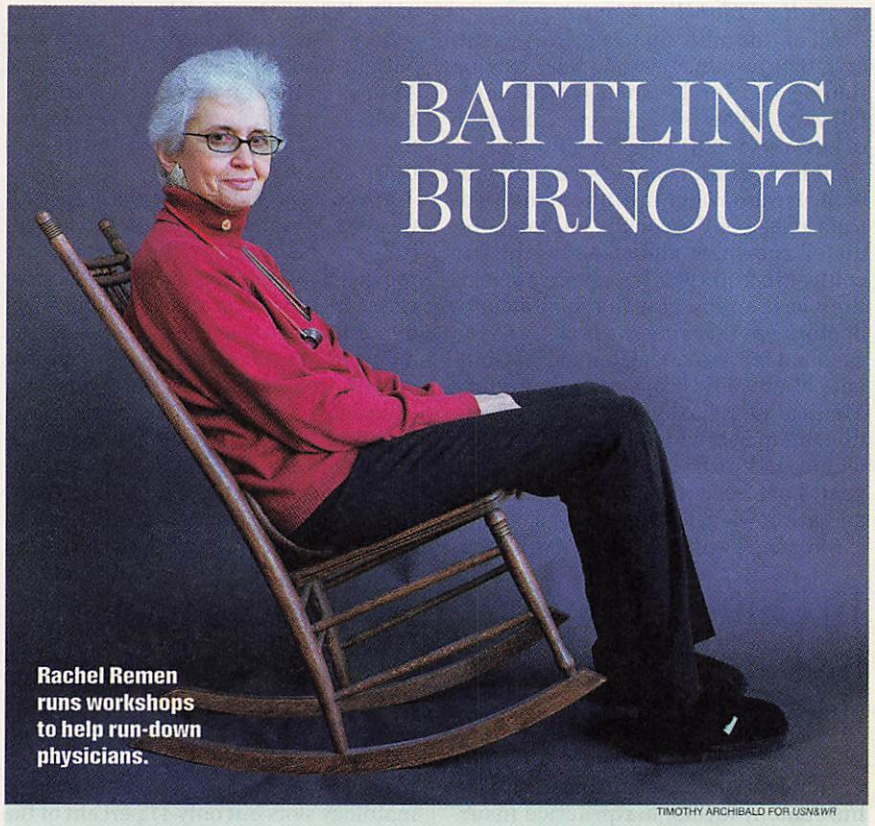
MISSING LINKS Jeffrey Sartin, an infectious disease specialist, misses the formerly close ties between doctor and patient that now have been severed.

them to produce perfect outcomes and are left holding the bag when something—even something out of their control—goes wrong. Says Stephen Sokolyk, a cardiologist in New Braunfels, Texas: "We have the responsibility but not the authority."

None of these problems are going away, because the dismay of the elders has now trickled down to newly minted healers. "Even young physicians who come out eager and excited at the end of their training program encounter frustrations early on," says Jack Lewin, CEO of the California Medical Association. When Merritt, Hawkins surveyed residents to see if they would still go into medicine if they had it to do over again, those frustrations surfaced. In 2001, 95 percent said they'd pick medicine over an alternative career. But in 2003—just two years later—that had dropped to 74 percent. "In my residency, if you had polled, at least half would have said that if they could go back to college they wouldn't choose medicine," says one new physician doing an endocrinology fellowship.

The doctor is out. While it's still very competitive to get into med school, some worry the best and the brightest may soon avoid the profession altogether. Med school applications are more than 10,000 below 1996's peak of 47,000. In a 2001 survey by the California Medical Association, two thirds of doctors were not advising their kids to enter the profession. "When I did my rotations, I had older physicians every other day telling me to get out now," says one recent med school graduate who subsequently dropped out of her residency program.

You may be thinking, "I don't like Monday mornings either, and I'm sure not getting paid as much as a doctor." Indeed, doctors still earn a very good living—an average of about $150,000 for family practitioners and two or more times that for lucrative specialties like cardiology. But doctors also spend many years in training earning little or nothing and face big bills from med school. In 2003, the median debt for graduates of public med schools was $100,000 and, for those graduating from private schools, a whopping $135,000, according to the Association of American Medical Colleges. (In 20 years, the median debt level has increased more than 4.5 times.) Meantime, malpractice insurance rates are still climbing. An obstetrician-gynecologist in Illinois could pay as much as $230,000 per year in Illinois or $90,000 in Los Angeles, according



BATTLING BURNOUT

Rachel Remen runs workshops to help run-down physicians.

TIMOTHY ARCHIBALD FOR USN&WR

Not all doctors are resigned to fading away amid the complexities of modern healthcare. Robert Rufsvold was a small-town doctor in a solo practice for years and found the thing he loved best about his job, connecting with patients, was often lost in the shuffle of administrative and other stresses. "It's so easy to lose sight of that connection every time I had to fill out a Medicare form," he says. A decade ago, he came to California for a workshop that led to the Finding Meaning in Medicine program, developed by Rachel Naomi Remen, a family and community medicine professor at the University of California–San Francisco. The program focuses on physicians who feel they're missing something in their careers. "They aren't practicing with the same joy or passion they once felt," says Rufsvold. In what are essentially support groups, doctors meet regularly to talk about things they don't usually share with one another, structured around themes like trust, fear, service, and compassion. (Those are deliberately vague, allowing doctors to discuss cases and patients who have particularly affected them.) Rufsvold did end up quitting his job in 2001—to work with Remen full time, giving more workshops.

Remen has also developed the Healer's Art, a course for med students that will be taught at 33 schools this year. Remen is concerned about the cynicism and loss of commitment she sees in both midcareer docs and those who haven't even begun to practice. "In the process of training, they somehow become depressed, cynical, alienated, and angry," she says. The course focuses on themes such as loss and recovering a personal sense of the Hippocratic oath. The students might discuss what it's like, for example, to treat someone with a problem they cannot fix. "Med school can be isolating, and it's easy to lose sight of why you're there," says Julie Connelly, who with colleagues teaches the Healer's Art at the University of Virginia School of Medicine. "They need skills in being good doctors, and they need to learn to take care of themselves." *–K.H.*

to *Medical Liability Monitor*.

All of this adds up to a growing concern that people may soon have trouble finding a doctor. Estimates of the shortfall vary. Miller is predicting a shortage of between 90,000 and 200,000 physicians by 2020. Richard Cooper, director of the Health Policy Institute at the Medical College of Wisconsin, has long predicted shortages and also says the gap could hit 200,000 by the same year. Both urge an increase in the number of doctors being trained, which has been stagnant for years. The Council on Graduate Medical Education, the American Medical Association, and the Association of American Medical Colleges, all of whom had projected surpluses in the past, have recently changed positions and acknowledged the problem.

Shortages will (and do) vary by geographical area, depending on reimbursement levels, malpractice insurance rates, and the cost of living. The problems are always grim in rural regions—the National Rural Health Association says that 25 percent of the population lives in rural areas, though only 10 percent of doctors practice there. Most experts say shortages of primary-care physicians will occur mainly in these parts of the country—primary care isn't appealing for its relentless office schedule and relatively low compensation. (Last year, the Task Force on Wisconsin's Future Physician Workforce said that the state is already short 506 primary-care physicians, with no relief in sight.) Already underserved inner-city areas may also be at particular risk. African-American doctors, who are far more likely to treat minorities in these urban areas, are no less bummed out than the rest of the profession; a survey of African-American doctors sponsored by the National Medical Association last year found that most were dissatisfied with practicing medicine.

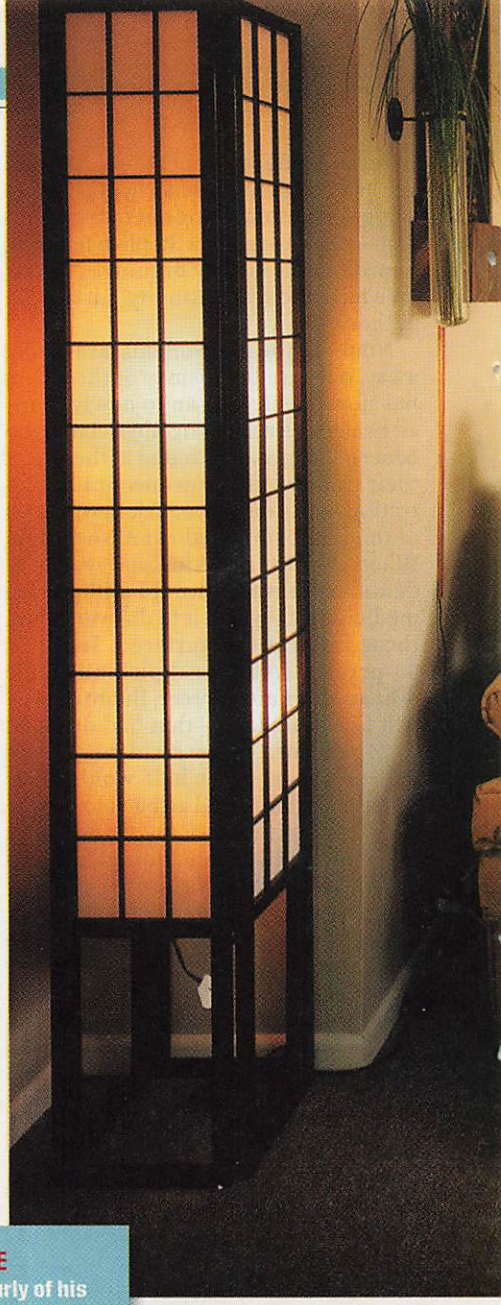
In California, where the cost of living is high, there are shortages of primary-care docs, neurologists, and surgical specialists. "The wait is three weeks to a month to see a pediatric neurologist, and pediatric nephrologists are as rare as hens' teeth," says Harvey Cohen, head of pediatrics at Stanford University School of Medicine. Already, Merritt, Hawkins reports that the average wait for a new patient wanting to see a cardiologist is 37 days in Boston and 22 days in New York. For an obstetrician-gynecologist, the wait is 45 days in Boston and 31 days in San Diego.

Specialty problems. In certain specialties like geriatrics, cardiology, neurosurgery, and oncology, the shortages are projected to be nationwide, even in areas with a high concentration of doctors. Demand for their services will rise as the baby boomers age and develop chronic conditions, but there isn't a corresponding surge of interested students.

Instead, today's med students are gravitating toward nonsurgical specialties with regular hours. In last year's "match" of new grads to postgrad medical residency programs, grads of U.S. med schools filled 97 percent of the dermatology slots but only 41 percent of the family med slots. There were about 2.5 applicants for every family medicine position open and about 14 for every radiology position. The American Association of Neurological Surgeons said last year that demand was vastly outstripping supply and noted that the field isn't perceived by med students as offering a regular schedule or enough personal time. Some specialities may change training to attract more doctors. The American College of Cardiology, for example, is considering whether to trim the current six-year training by a year, cutting out the interventional procedures that aren't done by general cardiologists anyway. That would increase the supply as well as possibly attract candidates turned off by the longer training period.

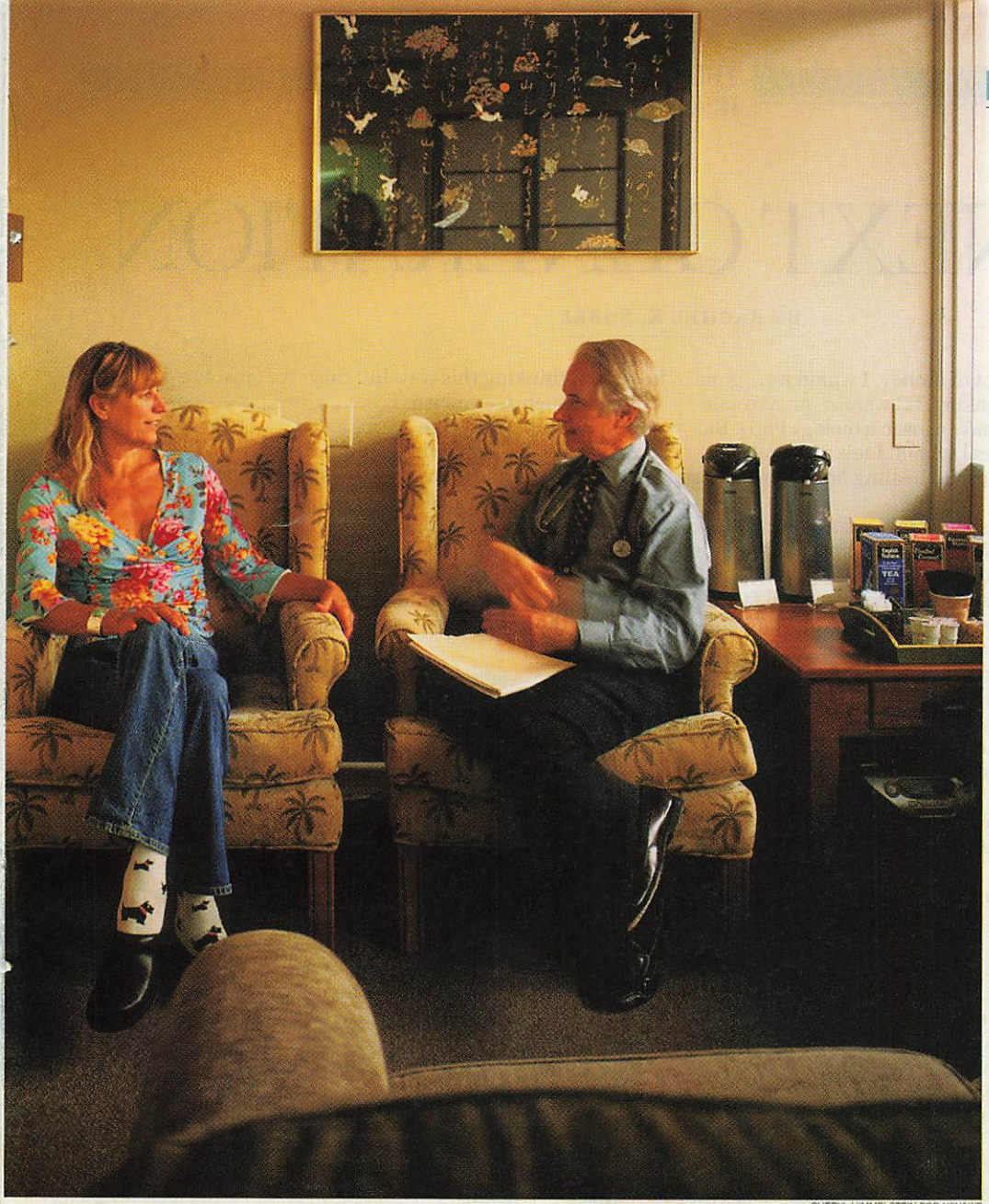
That's not to say that young doctors are slackers or that no one is interested in the most academic specialties. But as a group, they are thinking very differently about their careers than did their predecessors, refusing to put medicine above family and personal time. One saying: The R.O.A.D. to happiness lies in radiology, ophthalmology, anesthesiology, and dermatology.

In California, where the cost of living is high, there are shortages of primary-care docs, neurologists, and surgical specialists.



ELITE CARE
The hurly-burly of his old practice bothered Paul Ryack, so he switched to a system called MDVIP, in which he has fewer patients and more time.

"There is a generational difference in what we see as important in our careers and personal life," says Jennifer Shu, immediate past chair of the American Medical Association's Young Physicians Section. "Whereas career might have defined you in the past, it doesn't anymore." She and her husband are a good example: She took two years off to have children and now works part time as an instructor of pediatrics and medical director of the nursery at Dartmouth (and writes books in her off time), and her husband is back at school for public health and outcomes research, with an eye toward a career in epidemiology. "I have to take care of my house, my own life, and my



CHERYL HIMMELSTEIN FOR USN&WR

son—I make limits," she says.

Statistics show that women—who now make up the majority of med school applicants—work fewer hours than male physicians do. But this desire to have a life is more generational and linked to expectations about what a medical career will and will not provide these days. "It's very clear that all physicians are looking towards having a life outside their medical practice," says Getto of the University of Wisconsin.

Meantime, doctors already on the job may consider changing their practice to adapt to the new realities—often in ways that affect patient access, especially for the poor (the rich can always pay cash or buy more comprehensive insurance). Only 11 percent of those elusive Boston cardiologists surveyed by Merritt, Hawkins accept Medicaid. About 17 percent of family practitioners nationwide don't take new Medicare patients, and those figures are worse in metropolitan areas. A 2002 study in California found only 58 percent of the state's doctors were accepting new HMO patients, while a third of specialists had no HMO patients at all. Some are turning to cash-only systems. All these restrictions squeeze out the poorer segment of the patient population.

A handful of physicians are finding relief by turning to so-called boutique, or concierge, practices, typically charging an annual fee to cover preventive services not covered by Medicare. A perhaps not-so-coincidental benefit is that the extra fees mean a smaller practice, which in turn means less waiting time and more access to your doctor. Though the $1,500–$1,800 annual fee has been called elitist, Darin Engelhardt, chief financial officer and general counsel of MDVIP, which provides business support services to boutique practices, says only a tiny fraction of doctors have a practice appropriate for this kind of care. For the doctors who do sign up with his and other services, "there is a uniform theme—the desire to be able to take back control of a primary-care practice," he says.

Scant rewards. In a special report in the *New England Journal of Medicine* last year, physician and journalist Abigail Zuger compared the discontent in medicine to similar feelings in other professional fields, including law, nursing, and teaching. Maybe, she says, doctors are just no longer isolated from the pressures that plagued their colleagues in other professions. "It is an exception whose time has finally expired," she concluded.

There are still plenty of doctors who see their work as a higher calling or at least love their jobs. And some studies buck the image of disgruntled docs: The *Journal of the American Medical Association* reported last year that most doctors are still satisfied with their jobs, though they voiced unhappiness with the administrative aspects. When done right, medicine "is one of the most deeply rewarding lifestyles in the world," says Remen. But many docs are feeling those rewards are only available by practicing medicine on their own, radically revised terms.

Paul Ryack feels invigorated again—but only after making big changes. He joined MDVIP, and his practice is down to 600 patients. Now he spends as much as 90 minutes with some of them. "I'm enjoying what I'm doing again," says Ryack. "I don't worry that I'm missing something because there's a line at the door. My quality of life has improved, and my patients love it." His is only one solution to the problems of practicing medicine these days, but the others that are appearing will also leave gaps that the country has not yet figured out how to fill. ●

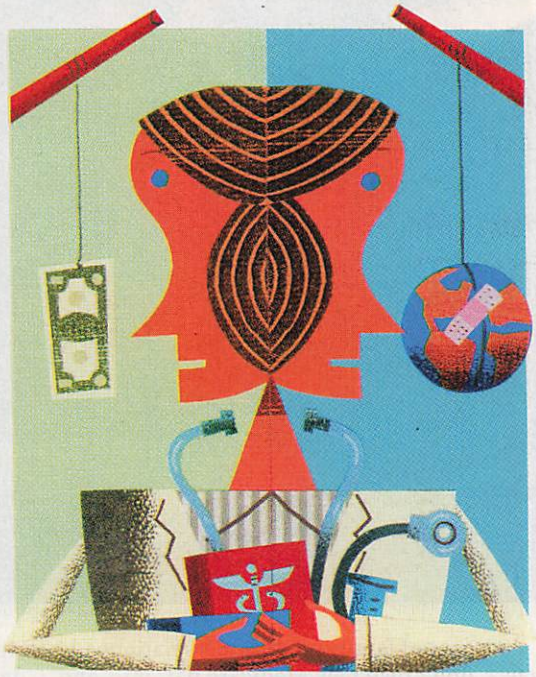
THE NEXT GENERATION

BY RACHEL K. SOBEL

If I had wanted to make a lot of money, I would have gone straight into investment banking. If I were enamored solely of science, then I would have chosen a biology Ph.D. But I decided to apply to medical school. I felt a calling, a desire to be engaged in the special healing bond between a doctor and a patient.

At the same time I would have been blind not to notice a weakening of that bond and the ugly cynicism seeping into my chosen profession. The summer before I left for medical school, I read of walkouts by doctors in several states, induced by high malpractice insurance premiums and concerns about frequent lawsuits. I also heard about the rise of "boutique medicine" aimed at rich patients. Friends who had started med school a few years ahead of me already gave off a sense of aloofness and fatigue. When did this cynicism start, I wondered? And how do I maintain the sense of idealism I set out with?

My first two years, spent mostly in the classroom, nourished that idealism. To learn about the diseases that I would soon treat energized me. Even more important, I was surrounded by classmates who fueled each other's passion. Some taught science to disadvantaged students; others held health fairs for Hispanic and Asian children. On the last evening of our smoking-cessation group for the homeless, I felt a rush of hope in the room, for the participants who had thrown out their lighters and cigarettes—and for my classmates and our future in medicine.



I felt a rush of hope in the room... for my classmates and our future in medicine.

Running into reality. But this year, my third, has brought a loss of some innocence. As I trained on the hospital wards, I was surrounded by unhappy, jaded residents—med school graduates doing their first stints as working doctors. These residents were my teachers, and they griped about the "bitchbox" or pager that they had to wear and about bothersome patients, such as "High-Maintenance Mom." Cynicism certainly catches on. I was stunned how quickly I had started to change. Just a few months in, I rejoiced with one young doctor when our frail, demented patient was finally transferred to a nursing home. We celebrated not because we had helped him—though we did, a little—but because we were relieved that he was finally off our hands. Another classmate ruled out a specialty she had long considered, because the patients were too needy. "Too needy?" she said. "I can't believe I am thinking this way, but they were just too draining."

But as much as cynicism is contagious, so are compassion, optimism, and hope. One professor required us to include in our case presentations what our patients like to do for fun. He understood that while wading through a sea of data about a patient, it was easy to dehumanize care. The woman with Marfan syndrome and a serious heart problem, it turns out, had been an avid hoops player. The man with cocaine-induced chest pain—he's a serious stamp collector.

One resident showed me that even while being bogged down with paperwork and beeping pagers, taking a few minutes to do what's not "required" is still possible—and can make a real difference. In the clip of a busy day, he found time to counsel a homeless patient, a former lawyer who was diagnosed with alcohol-induced heart disease, about the very serious cardiac consequences of his addiction. "I always thought alcohol was bad for my liver," the patient said, somethat surprised. "I didn't know it could damage my heart." The patient was discharged, newly informed and newly hopeful, holding a list of local sobriety programs.

Fellow students have reminded me, as well, that we possess strong medicine—not the drugs we can give to patients but our words, the timbre of our voice, and the touch of our hands. A few months ago my classmate Julie, who was transferring her patient's care to me, brought me to his bedside to introduce us. A pungent sour odor wafted through the air. There was a pink tray by his side to catch his frequent vomiting. The thin, white-bearded patient greeted her like a close relative: "Julie, my darling, I've been waiting for you."

The man, recently diagnosed with end-stage lung cancer, was troubled. His wife had suddenly stopped coming to visit him in the hospital. He worried that she was too scared to see him go, that she could smell the aroma of death in the air. "Do I smell like death, Julie?" he asked, patting his lips after hocking up a small concoction of phlegm and blood. Julie placed her hand on his bony shoulder, bent over toward his straggly beard and took several deep whiffs. "Absolutely not. Don't you worry one more minute about that." He smiled, looking relieved, and then he thanked her. And I smiled too, to thank Julie for helping to restore my faith in this extraordinary relationship. ●

ILLUSTRATION BY RICH LILLASH FOR USN&WR

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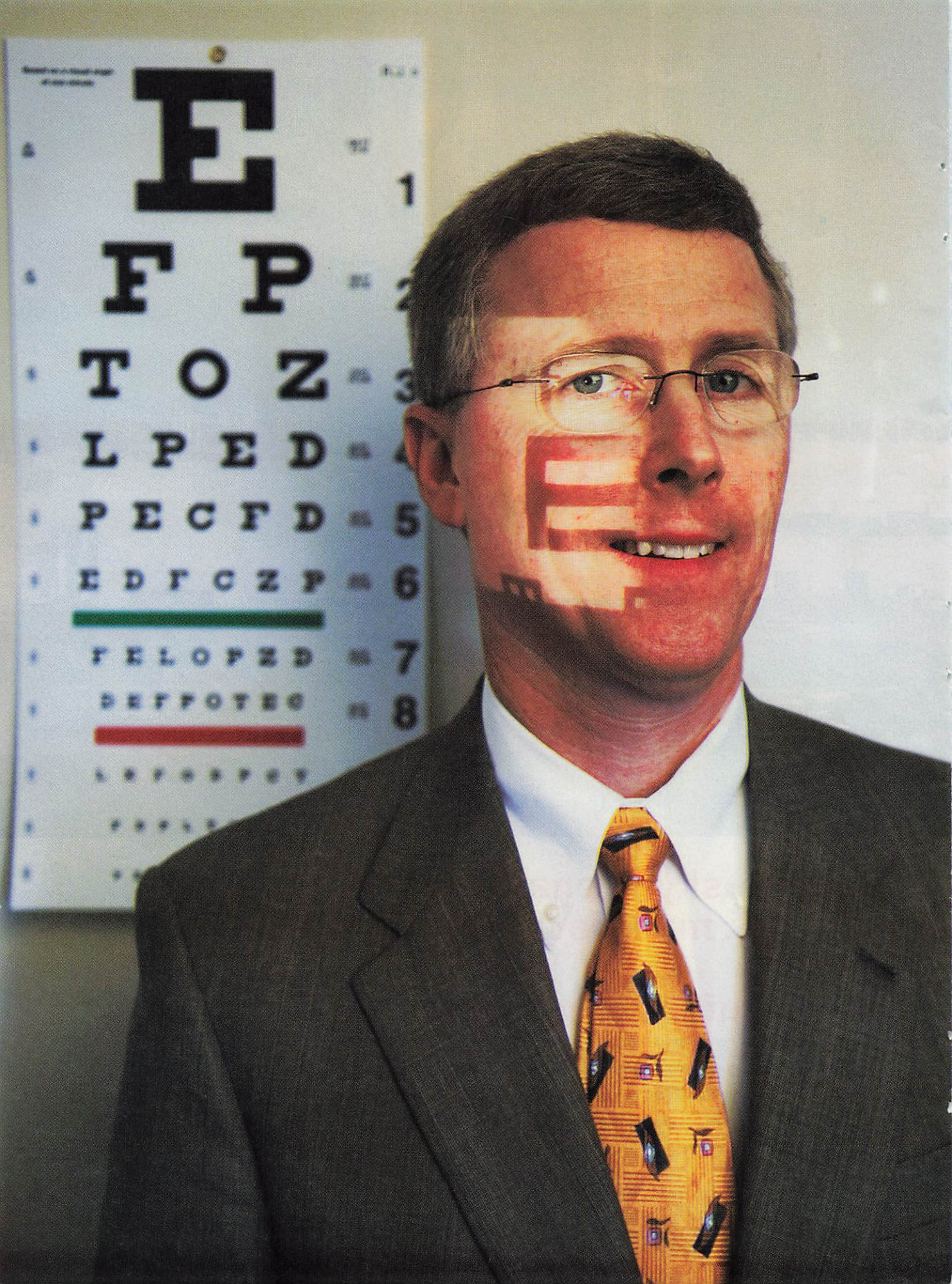
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Medicine's Turf Wars

SPECIALISTS WITHOUT M.D.'S ARE PUSHING FOR MORE MEDICAL POWER. ARE THEY READY—AND ARE YOU?

BY CHRISTOPHER J. GEARON

You've probably noticed it at your own doctor's office, the subtle yet revolutionary changes in the way Americans receive their healthcare. The tipoff may have come when a physician assistant wrote your child a prescription instead of the pediatrician. If you've recently switched doctors, chances are you saw a nurse practitioner and not the primary-care physician listed on your health insurance card. Perhaps you live in a place where you can bypass the doctor and go directly to the pharmacist for immunizations. Or maybe you're one of the millions of patients directly spurring these changes, deliberately asking for these providers because you're fed up with your doctor, had to wait too long to see him, or simply couldn't afford it.

Nonphysician clinicians—nurse practitioners, nurse anesthetists, dentists, optometrists, chiropractors, and others—have become prominent health providers. Often working alongside doctors, well-trained, nonphysician clinicians provide frontline medical care to patients increasingly needing preventive care or monitoring for diabetes, congestive heart failure, and other chronic diseases. These new faces of American medicine are more willing to go to rural or inner-city areas and to work beyond the limited office hours typically kept by physicians. Minneapolis nurse practitioner May Hang, for instance, sees a wide variety of patients early mornings and nights at a Target store that houses her mini medical office, MinuteClinic. The clinic is designed to treat a limited set of common acute ailments, including ear, bladder, and sinus infections and strep throat. No appointments are necessary, and visits take only 15 minutes.

Yet as health professionals such as Hang have advanced into territory once held solely by doctors, a larger medical turf war has begun. The battles take place away from patients and are fought before state legislatures, the courts, and other venues as non-M.D. professions try to broaden their responsibilities even further. Oklahoma recently allowed optometrists to do limited surgery, podiatrists in California can perform partial foot amputations, and Idaho last year removed requirements of physician supervision over nurse practitioners and certified nurse midwives, giving them more freedom to practice. Nurse anesthetists in New Jersey have been lobbying for the same type of autonomy. And right now, psychologists in Tennessee are fighting for the right to write prescriptions—a battle the non-M.D.'s have already won in New Mexico and Louisiana.

Their primary weapons are the issues of access and patient safety. In Tennessee, for example, psychologists argue that patients must typically wait six weeks for an initial psychiatrist's appointment; low-income patients wait several months. The result is that many people don't get proper treatment, the psychologists contend. Roughly three quarters of the people in Tennessee who seek help for depression are treated by physicians with only limited training in mental disorders. Psychologists, who tout Ph.D.'s and many years of training, say they're better equipped than an internist or OB-GYN to prescribe drugs for emotional conditions.

Psychiatrists, not surprisingly, don't agree. "The cure to the access problem being proposed is worse than the disease," says Steven Sharfstein, president-elect of the American Psychiatric Association, adding that psychologists' proposed medical education equals a few weeks of what physicians get in medical school. "We need more psychiatrists, but I don't think the solution is to entitle or enable poorly trained physicians to provide a level of medical care that is potentially unsafe."

Behind the claims about safety for patients, however, lurks the specter of self-interest on both sides. "It's a political and economic issue," says physician Richard Cooper, professor of medicine and health policy at the Medical College of Wisconsin. Physicians want to maintain control of care and the financial rewards that come with it. They don't want to be undercut in the market by less costly providers.

Indeed, rising healthcare costs are a huge factor for consumers, health insur-

A DIFFERENT VIEW
Optometrist David Cockrell (left) does a lot more than measure nearsightedness in his Oklahoma practice; he can do laser and non-laser eye surgery.

SCOGIN MAYO FOR *USN&WR*

ers, states, and employers all looking for less costly alternatives. "Nonphysician providers continue to achieve enhanced stature," notes Andrew McKinley, an analyst for Health Policy Tracking Service in Falls Church, Va. "There is growing support for the concept that the public health is best served by the broadest access to primary care, along with the safe use of pharmaceuticals." And for many, that concept is best supported by clinicians who don't have medical degrees.

advanced practice nurses show the care they deliver is equal to or better than that delivered by physicians.

Robert Wise, vice president for standards and survey methods at the Joint Commission on Accreditation of Healthcare Organizations, the oversight group that inspects the nation's hospitals and healthcare facilities on quality and safety, says that "the critical issue here is not what they are allowed to do, but do they know what they can't do?" A wide scope of practice doesn't mean that a provider, physician or not, knows it all. They should refer patients to other clinicians when appropriate. "If they know what they can do and what they can't do, they are [most likely to be] a pretty safe practitioner."

Safety studies have played a major role in the mother of all turf battles, which has been waged between those two professions, anesthesiologists and nurse anesthetists, who ensure that, every year, more

PLAYING IT SAFE

The safety issue isn't just a "he said, she said" debate. Research has shown that many nonphysician providers perform safely, or at least as safely as physicians do, in their expanded roles. But that doesn't mean there's nothing to worry about. "In the main, it's been very safe," notes Cooper, "because roles have expanded commensurate with training and supervision." Cooper, who studies the enlarging roles of nonphysician clinicians and writes on quality and patient safety, adds that research, however, has not been done on leading-edge practices now being undertaken by some of these providers. "There are no outcomes on podiatrists doing amputations," and that's just one example, Cooper notes.

What research has established most notably is that an assortment of nurses with advanced training, including nurse practitioners and certified nurse midwives and other registered nurses with master's- or Ph.D.-level education, are safe. They relieve our pain during surgery, deliver our babies, treat our kids' asthma, care for our aging parents, and help alleviate the suffering of those with AIDS/HIV and other devastating conditions. More than 100 studies have examined, for example, the care delivered by nurse practitioners. "To my knowledge, there is not a single study showing negative impact of [nurse practitioner] practice on health," says Linda Aiken, director of the University of Pennsylvania's Center for Health Outcomes and Policy Research and a nursing professor. She adds that numerous studies of

than 26 million Americans feel no pain when they go under the knife. In general, anesthesia is extremely safe (only one death occurs for every 250,000 times it's administered, a dramatic improvement since the early 1980s, when two deaths occurred per 10,000 anesthetics administered). And 65 percent of all anesthesia care is delivered by certified registered nurse anesthetists, critical-care nurses with a graduate degree in anesthesia, who train for several years in order to sit for certification. Medicare has long recognized their qualifications and reimbursed them for their services. The two professions are extremely courteous to one another when individuals meet in an operating room.

But that courtesy masks a fierce dispute raging between the American Society of Anesthesiologists and the American Academy of Nurse Anesthetists. One part of this row involved nurse anesthetists' wanting to be paid for services rendered in hospitals and surgical centers without physician supervision. It has been left up to each state to allow—or disallow—that care without physician oversight.

To date, 12 mostly rural states have said there's no need for docs. The states have been swayed by safety data on anesthesia providers. "If there is a difference, the studies to date have not shown that," says Cooper.

Now the battle has shifted to doctors' offices. Florida has been the flashpoint. During the late 1990s, the number of office-based surgeries—largely lucrative cosmetic surgery operations—in the state skyrocketed. The practice wasn't well regulated, office facilities often lacked emergency care, and there were a number of highly publicized deaths.

"Office surgery is like the Wild West; it's the last frontier," says Rebecca Welch, president of the Florida Society of Anesthesiologists. While there are no data showing that CRNAs have trouble providing safe anesthesia in office settings, Welch says, "we feel like we are the experts" with a medical school background. Florida's state medical board apparently agreed and created standards for office-based surgeries that insisted anesthesiologists had to supervise CRNAs.

Nurse anesthetists felt the impact immediately. Victor Ortiz, a CRNA from Davie, Fla., says that right after the supervision rule took effect in 2002, "70 percent of my income got swept away." Why? Most surgeons concluded it wasn't economical or necessary to have both an anesthesiologist and a CRNA in their office. "[The medical board] was saying you're unsafe . . . but you read unbiased studies, and they show that you are safe. This was about control and turf," Ortiz says. So Ortiz sued the state medical board. Last summer, a Florida appellate court ruled the board overstepped its bounds with the anesthesiologist supervision rule, a decision affirmed last month by the Florida Supreme Court. "I'm elated," Ortiz says.

Now, another anesthesia battle is shaping up in New Jersey. The Garden State has passed an office-based-supervision rule similar to the one recently knocked down in Florida. It goes into effect in February. Local nurse anesthetists are gearing up for a court challenge, and they hope the outcome will be similar to Florida's as well.

KAREN KUEHN FOR *USN&WR*

PILL POWER
Talk and behavior therapy are only part of psychologist Elaine LeVine's arsenal. She can also prescribe medicine for her patients.

The federal government concluded that the psychologists were indeed trained to provide patients safe pharmacological care.

POWER OF THE PAD

The right to write prescriptions is the subject of another skirmish. The psychologists pushing for prescribing privileges in Tennessee and five other states will point to the gains they've made in New Mexico in 2002 and Louisiana last year, perhaps their best evidence and best way to assure doubters that they know what they are doing. In New Mexico, for example, psychologists have to take 450 hours of classes in psychopharmacology and other sciences, as well as log years of supervision and collaboration with physicians in order to prescribe. Advocates will also be holding up a Department of Defense experiment that followed the patients of 10 psychologists trained to prescribe medications, a demonstration that ran from 1991 to 1997 with program graduates going on to prescribe medications in conjunction with other kinds of therapy to active and retired members of the military and their families. The federal government and outside evaluators concluded the psychologists were indeed trained to provide safe pharmacological care. But psychiatrists argue about the results anyway. They say that the DOD training was more comprehensive than the training specified in legislation pushed in the states.

But Elaine LeVine, a Las Cruces psychologist, who helped persuade New Mexico's Legislature to give her colleagues prescribing privileges, says far from endangering her patients by writing them prescriptions, her patients will do better when she can choose their meds. She has no problems with psy-

chiatrists—when enough of them are available for patients. It's physicians without mental health training but with a prescription pad who give her pause. While a patient may see his primary-care provider for only very short visits, she notes, psychologists' patients may spend an hour a week in therapy.

As the two professions debate the finer points, Carmen Catizone, who has seen a lot of prescription pads, chuckles. Catizone, executive director of the National Association of Boards of Pharmacy, has seen many professionals duke it out over nonphysician prescribing privilege, including his own group. Pharmacists used to only make and hand out medications but today have authority to vaccinate patients in 37 states and can prescribe "morning after" emergency contraception in California, New Mexico, Alaska, and a handful of other places. Pharmacist prescribing generally is authorized under collaborative agreements with physicians but also allows pharmacists to monitor patients' ongoing conditions.

In the late 1960s and 1970s, the prescription battle was waged between M.D.'s and doctors of osteopathy. Today, like M.D.'s, D.O.'s have unlimited, inde-

THE DRUGGIST IS IN

Steve Wienner has just gotten a call from a longtime customer. He listens intently while continuing to mark off the bottles behind the counter of Mt. Vernon Pharmacy, his Baltimore drugstore. "Is the muscle weakness worse?" he asks. "I would increase your fluid intake, but if you're not feeling better in a few days, then call your doctor." He hangs up the phone, continues checking prescriptions, and starts to get out ingredients to customize an acne prescription for a teenager. "A lot of what we do is more than one thing at a time," he says.

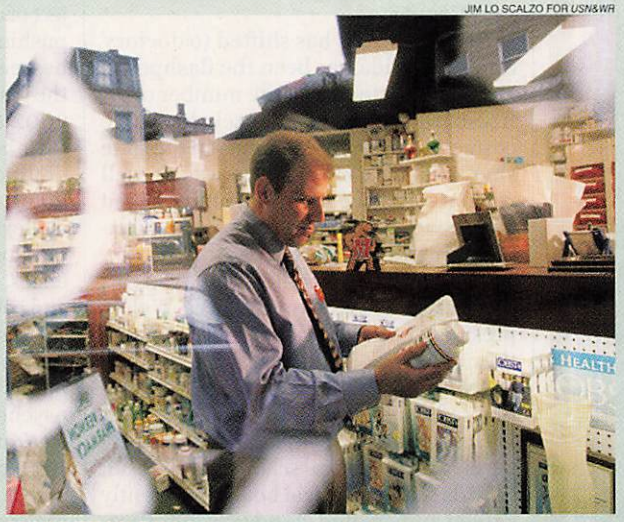
With drugs playing an ever larger role in healthcare, pharmacists like Wienner are stepping to the forefront of healthcare. Between 1995 and 2003, the number of prescriptions sold each year in the United States rocketed up from 2.1 billion to 3.2 billion. Our growing drug habit means more prescriptions to fill and more customers in front of the pharmacy counter.

And those customers are looking to drugstores for more than just pills. For decades, nursing homes and hospitals have employed pharmacists who review patients' drug regimens and offer suggestions, but now these same services are being taken out into retail drugstores. Many drugstores around the country, including large chains such as CVS, are starting up programs to get pharmacists out from behind the counter and talking with patients about how to manage chronic diseases or complex drug regimens.

"The pharmacist is an underutilized asset in the community," says Mark Gregory of Kerr Drug, a North Carolina chain that was one of the first to train its pharmacists as consultants. Like CVS, Kerr believes that helping patients become more knowledgeable about their medications will make them feel better and spend less time in doctors' offices and may reduce their healthcare bill.

Negotiations. Pharmacists have also had to become insurance experts. For many, one of the biggest tasks each day is negotiating with insurers and doctors to get a patient's prescription covered. Most insurance plans have lists of preferred drugs, and if patients come in with a prescription for another drug, they have to either shell out the cash themselves—and sometimes that's hundreds of dollars—or get their doctor to rewrite their prescription for the preferred medication. At Wienner's store, right after the customer called about muscle weakness, another call comes in from a patient who has been waiting two months for his medications because the doctor has not approved a prescription switch. "I have faxed your doctor many times," says Wienner. "We're trying but . . ." and his voice trails off. He says that he no longer has the time to follow up as he once did and act as an advocate for his patients. "At some point, we have to say, 'I'm sorry, we've had 70 other people today that we've had to do the same thing for, and we don't have time to call anymore.' It's disgraceful."

JIM LO SCALZO FOR USN&WR



MORE THAN PILLS. Steve Wienner dispenses advice, too.

A survey sponsored by the National Association of Chain Drug Stores found that about 20 percent of a pharmacist's time was spent dealing with insurance issues. Pharmacists ranked that as one of the most frustrating parts of their job. "The thing that's being sacrificed is communication with the patient," says Daniel Hussar, a professor at the Philadelphia College of Pharmacy.

Wienner still tries to talk with each person who comes through the door. "Have a great day!" he calls to a regular as he reaches to take another phone call.

–Elizabeth Querna

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pendent prescribing authority in every state. In the early 1980s, optometrists battled ophthalmologists for the privilege. Now, optometrists can prescribe at least some eye-related medications in every state. Physician assistants, a profession devised by physicians to work under their supervision, had a much easier time in the early 1990s obtaining the ability to write prescriptions under the auspices of M.D.'s. Nurse practitioners have gotten some level of prescribing privileges in most states. Such battles cool as few significant problems are found and as more states grant a particular profession prescribing privileges. Instead, organized medicine focuses on preventing professions just starting to seek prescribing authority from getting it.

KNIFE FIGHTS

Even mightier than the prescription pen, when it comes to medical practice, is the sword—actually, the scalpel. And fights are breaking out around the nation over whether nonphysicians can wield one. Such fights, often fought in the absence of quality data, are among the feistiest around—and some of the most difficult for patients who need to choose which hand will do their surgery.

One such hand could belong to Richard Joseph. He finished his residency in 1977. He started out in trauma surgery, rebuilding faces mangled by car accidents and violence in Jacksonville, Fla. Eventually, he got permission from Jacksonville's Baptist Medical Center to perform face-lifts as well. Now, his private practice includes face-lifts, eyelid surgery, Botox injections, and the occasional impacted wisdom tooth. Joseph is an oral surgeon, or, more properly, an oral and maxillofacial surgeon, a dental school graduate, and he's never been to medical school.

Oral surgeons are increasingly getting involved in doing cosmetic surgery. In a world of unhappy doctors and insurance hassles, cosmetic surgery looks like a good place to be. Oral surgeons are, technically, dentists. But they do at least four more years of training after dental school, when they learn to cut open, sew up, and improve the appearance of faces and necks, and they say they are just as qualified as plastic surgeons to do cosmetic surgery. Much of the facial trauma in the nation is handled by oral and maxillofacial surgeons; hospitals designated as Level I and Level II trauma centers are required to have one around to deal with facial injuries. And oral surgeons don't do the things you usually associate with dentists.

STEVE NIEDORF FOR *USN&WR*

MINUTE CLINIC At her walk-in clinic in a Minneapolis Target store, nurse practitioner May Hang treats ear, bladder, and sinus infections, as well as strep throat.

Oral and maxillofacial surgeon Mark Steinberg, who teaches at Loyola University Medical Center in Chicago, says he hasn't filled a cavity in 25 years.

Plastic surgeons, for their part, go through medical school and several years of training in general surgery and plastic surgery. Oral surgeon training just doesn't match up, says Scott Spear, a plastic surgeon at Georgetown University Hospital and the president of the American Society of Plastic Surgeons. He and his colleagues insist that their concern is only for patient safety and good surgical results; predictably, oral surgeons shoot back that plastic surgeons just want to keep others off their lucrative turf.

State regulations that define dentistry have been the arena for the plastic surgeons' and oral surgeons' dust-ups. At issue is the American Dental Association's 1997 definition, which states that dentistry includes work on "the oral cavity, maxillofacial area and/or the adjacent and associated structures."

That is so ambiguous as to be useless, scoffs Bill Seward of the American Society of Plastic Surgeons. "The jaw is connected to the neck, which is connected to the torso. You can drive a Mack truck through that hole." He claims the "adjacent and associated structure" language gives oral surgeons the right to do breast augmentations, abdominal liposuction, or anything else they want, but oral surgeons point out that the definition also says they're only supposed to do work within the scope of their training.

Yet despite the plastic surgeons' objections, 16 states have adopted the ADA's definition, and several others also give permission for oral surgeons to do any procedures they have the training and credentials to do—which could include cosmetic surgery.

A patient who wants cosmetic surgery by a qualified surgeon—oral or any other—is bound to be a little confused. But there are some common-sense checks to make. Check to see if the surgeon is board certified, for example, and how many of the procedures the doctor does in a year. If the surgeon has hospital privileges to do your procedure, that's an indication that his or her peers think he or she is qualified.

In another cutting-edge battle, organized medicine has gone on the warpath in Oklahoma, the only state that allows optometrists to do laser and nonlaser eye surgeries. The state was apparently swayed by the access argument, specifically Oklahoma's greater supply of op-

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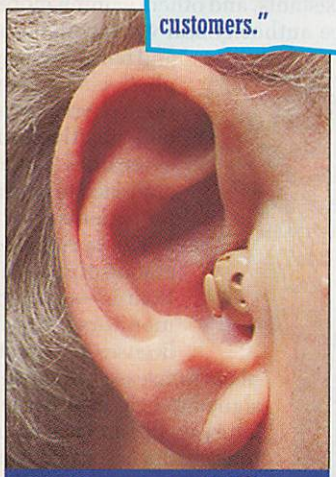

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These battles, without good information for patients to make good decisions, have made many people quite concerned.

tometrists than ophthalmologists. Last year, ophthalmologists tried to overturn the law authorizing the scope of optometry practice, charging that it gave optometrists too much surgical authority. The challenge didn't quite work out. Instead, Oklahoma's Legislature and governor clarified optometrists' practice boundaries, allowing these nonphysicians to continue scalpel surgery around the eyelids and lashes and other eye-related surgeries. "It was politically motivated, and they picked a fight and it backfired on them," says Stillwater, Okla., optometrist David Cockrell, who is president of the Oklahoma Board of Examiners in Optometry.

These battles, without good information with which patients can make good choices, have many people concerned. "Unless we drastically change course, patients will see a much more fragmented system, and it will be more difficult to know whom to see and the quality of care they deliver," says Robert Phillips Jr., director of the Robert Graham Center, a policy center sponsored by family physicians looking at primary-care and quality issues. The course change that Phillips recommends is more collaboration and less conflict. He notes that the widening responsibilities allied health professionals are getting shouldn't leave them isolated from physicians. Most nurse practitioners, physician assistants, and others gaining more practice authority still work collaboratively and harmoniously with physicians. In fact, one thing physicians and allied health clinicians agree on is that a team approach to care is best for patients.

This spring, the Federation of State Medical Boards—a group that monitors physicians' licenses and practices—plans to release a document designed to help healthcare regulatory bodies and legislatures to make better-informed decisions on scope of practice changes. One would expect the FSMB document to boost the physician side in the turf battles, but FSMB President and CEO James Thompson, M.D., won't show his hand. Thompson does say that he believes calls from the Institute of Medicine to forge more collaborative relationships are getting the attention of physicians, and he expects to see that trend continue over the next five to 10 years.

Calls for collaboration are all very well, but many observers think that stronger intervention is needed. Market forces—in other words, money or the lack of it—are going to continue to draw primary-care physicians away from patients and draw allied health professionals in to take their places. "The system of medicine is pushing people to the edges of their competence," says the Medical College of Wisconsin's Cooper. "Is this a crisis? No, it's not a crisis. But is the system pushing nonphysicians to the limit of their capability? I think so." ●

With Helen Fields

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the Front

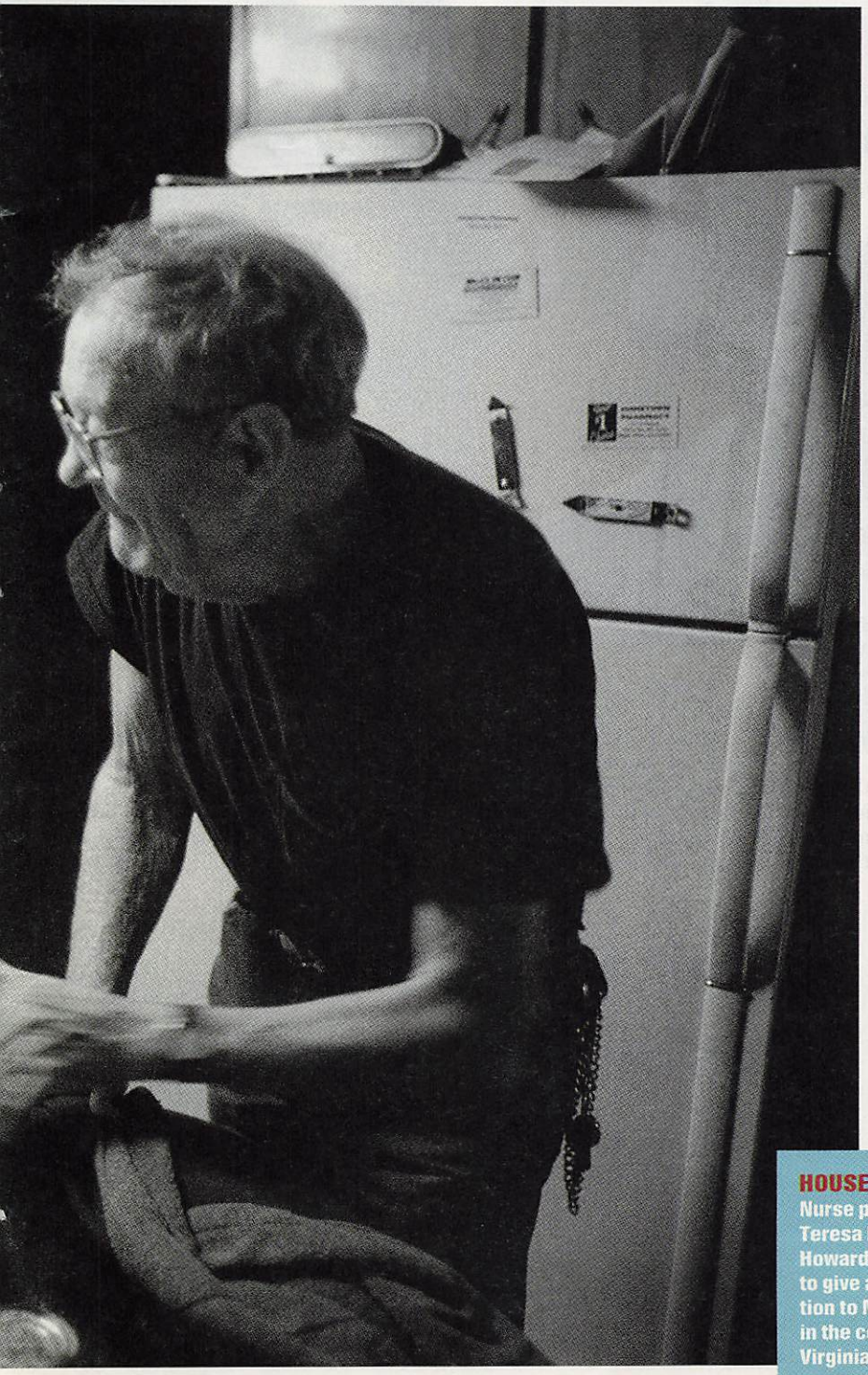
IN HAMLETS AND HIGH-TECH HOSPITALS, NURSES ARE TAKING ON BIGGER ROLES

BY SAMANTHA LEVINE AND ANGIE C. MAREK

When white-haired Harry Curry shuffles into the Minnie Hamilton Health Care Center in rural Grantsville, W.Va., he says he'll see only "his doctor." That's his name for Teresa Ritchie, the nurse practitioner who looks after the 71-year-old at this tiny complex tucked in the Appalachian hills. And it's not really a misnomer. The veteran nurse takes on everything from minor surgery to emergency room crises. Ritchie has admitting privileges at area hospitals, still unusual for a nurse, and can prescribe medication with just a doctor's checkoff. Her autonomy surprises her as much as anyone. "When I started out, nurses were not told we could think for ourselves," says the West Virginia native, who delivers care with a dollop of down-home gossip and finds ways to give her predominantly low-income patients free medicine. "We just did what a doctor planned out for us."

But those times are long gone. Many of the country's more than 2 million nurses are taking on jobs that were once the purview of physicians, like administering chemotherapy and running their own primary-care practices. They are carving new niches in fields such as genetics and computerized patient records, where nurses were once hard to find, and bringing philosophies oriented toward health promotion and problem prevention to geriatric care and case management. "When we are allowed to think outside the box, there is a lot we can do," says Jane Barlow, a University of North Carolina nurse who is developing a disability screening and intervention system for children in her home state. "In every situation, there is more that nurses can do if they feel empowered."

The seeds of nurses' liberation from doctors' white coattails were sown in the 1960s. That's when a nationwide shortage of primary-care physicians, especially in rural and



HOUSE CALL Nurse practitioner Teresa Ritchie teaches Howard Hawkins how to give an insulin injection to Martha Jones in the couple's West Virginia home.

inner-city areas, pushed many nurses into advanced roles. "Nurses were doing things that most people thought just physicians were doing, like seeing patients and recommending medication," says Lynne Vigesaa, who in 1972 became the first nurse practitioner in the state of Washington and later helped write the state's regulations defining and governing that role. Through the 1980s, the idea of nurses' doing more than just assisting doctors gained acceptance as patients began seeking out nurses—who seemed to have more time for them—and resistance from physicians' organizations eased. States began formalizing nurses' expanded roles. "It's pretty amazing, when you think about it," says Vigesaa, who now manages a dermatology clinic outside Seattle.

Filling a void. The advent of managed care also opened doors. The law defining health maintenance organizations was passed in 1973. But the idea—prepaid plans that enroll members and arrange their care from a designated network of doctors—brought on serious complications. The plans often tightly control how, when, and why doctors offer medical services. The reimbursements doctors get from the plans are prearranged but haven't all risen in step with the ballooning cost of healthcare. That problem now extends beyond HMOs to all insurance plans, doctors complain, which means they must see ever increasing numbers of patients to remain profitable. Those busy schedules have created voids in patient care—and nurses are filling them. "When patients call doctors for advice these days, many times nurses are the ones at the other end of the line," says Patricia Rowell, a senior policy fellow for the American Nurses Association.

Over time, as the hours and roles of medical residents and interns changed, many nurses with master's degrees who specialized in fields such as pediatrics were called upon to perform tasks once reserved only for the med-school set. Rowell, a pediatric nurse practitioner, remembers hearing of her colleagues in infant intensive-care units being allowed to insert breathing tubes down the throats of delicate babies. "It was an incredible thing," she says. These trends are continuing today as residents' exhausting schedules are further cut back—for reasons of patient safety.

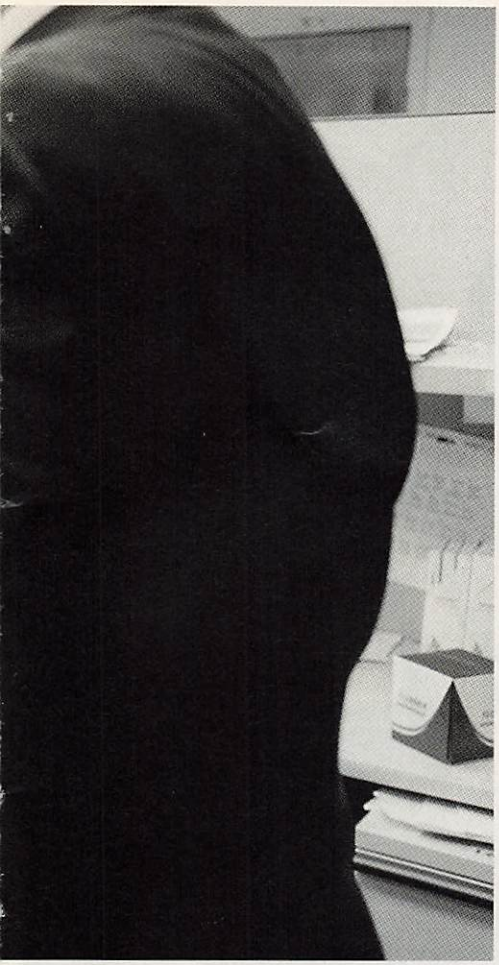
GOOD MEDICINE Ritchie talks with a drug company rep about ways to get free supplies for poor patients. Far right: She finds a hairline fracture in an X-ray.

As nurses are asked to do more, they are also trained to do more. In 1980, 60 percent of nurses received their basic education through on-the-job training courses in hospitals. That number was cut in half by 2000. During that same time, the share of nurses earning associate's degrees more than doubled, to 40 percent. The number of nurses pursuing master's degrees and doctorates has tripled over the past two decades—by 2000, one in 10 registered nurses had made the leap. And the number of doctoral programs nationwide has grown from 52 in 1990 to 93 today.

MORE NURSES NEEDED

Call it the shortage that won't quit. Job incentives for nurses that began in the 1990s lured more into the workforce. But not enough. The U.S. Department of Health and Human Services estimates that by 2020, hospitals will be shy almost 810,000 nurses. That represents a 29 percent vacancy rate, up from 7 percent today. "The shortages threaten to grow so big they'll cripple our healthcare system," says Peter Buerhaus, an associate dean at Vanderbilt University's School of Nursing. "We're headed for a crisis."

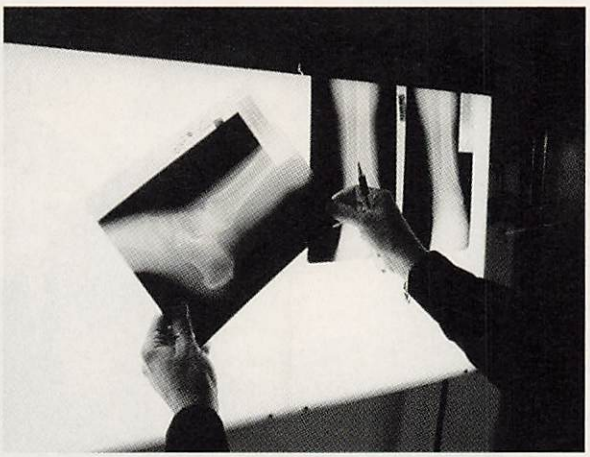
The trouble is that most nurses are now headed toward retirement. In the 1980s and 1990s, enrollment in nursing schools sank as young women took advantage of increased career opportunities in other fields. By 2000, the average age of RNs was about 43. In the past few years, high



By 2015, the American Association of Colleges of Nursing wants all nurses doing advanced practice work that now requires at least a master's degree—this includes nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists—to hold a doctorate of nursing practice.

Nurses already have rigorous training. Most undergraduate nursing schools require students to take a variety of courses, from statistics to biology, before they can even enter the nursing program. Once in a program, students' classes include anatomy and ethics, and they must complete several practicums. After earning an undergrad degree, every student must pass a nationally standardized test before officially becoming a nurse.

Rules governing what nurses are allowed to do with this training vary by state. "You sometimes push for 15 years, so hard, just to take one baby step," says Marie-Annette Brown, a nursing professor at the University of Washington who helped lobby to give nurses in her state more power to prescribe medication. Before such efforts, nurses could not prescribe controlled substances like morphine without doctors' supervision. That's still the case, though, in 37 states that demand a doctor's sign-off. But 27 states allow nurses to open their own private practices without a doctor in the house. Many nurses still have trouble, however, persuading insurance companies to reimburse them for their work.



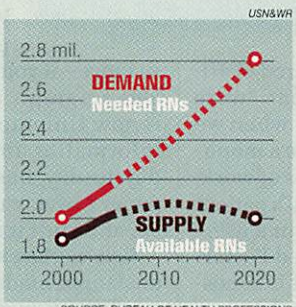
Whole-patient care. But more than the ability to prescribe drugs, nurses are pushing to practice a breed of care that bears their unique imprint. "More so than doctors, we focus on health promotion, the strategy of teaching our patients how to live healthier lives," Brown explains. This means helping patients manage their symptoms and chronic conditions and avoid health pitfalls like poor diets. "If I have a child with diabetes, I try to teach him to self-regulate his condition," says Rowell. "But I also tell him to . . . engage in after-school activities; don't be afraid to live a normal life."

Looking at the whole patient is critical for oncology nurse Ann Welsh. As a senior nurse in the chemotherapy division at the University of Pittsburgh Medical Center's Hillman Cancer Center, she is doing more than she could have imagined when she graduated with an associate's degree in nursing from Northern Virginia's Marymount University in 1973. At that point, she was given a little white nurse's cap and went to work on the National Cancer Institute's pediatric ward. "Early on, I was the liaison between the doctor and the patient," she explains. But through the 1980s, as more cancer treatment moved to an outpatient basis, her responsibilities grew to coordinating most aspects of her patients' therapy regimen. With her understated manner, Welsh, 51, gently administers chemo to hundreds of patients. Though she closely collaborates with Hillman's oncologists, there's nary a doctor in sight while she sets up complicated webs of intravenous drips for folks like Mario Urlini, a hearty 83-year-old who's getting his last treatment for non-Hodgkin's lymphoma. While Welsh connects the clear tubes, Urlini's wife, Grace, looks on and says: "I went through two major operations, and I never found a nurse like Ann."

Welsh also trouble-shoots problems with patients, such as sorting out whether an older man with worrisomely low blood counts can undergo needed cataract surgery. Patients call Welsh, not their physicians, with day-to-day concerns. "I know them inside and out, so I can assess if there is a big change," she

wages have drawn former nurses back to hospitals—but two thirds of the new hires are older than 50, making things more lopsided than ever.

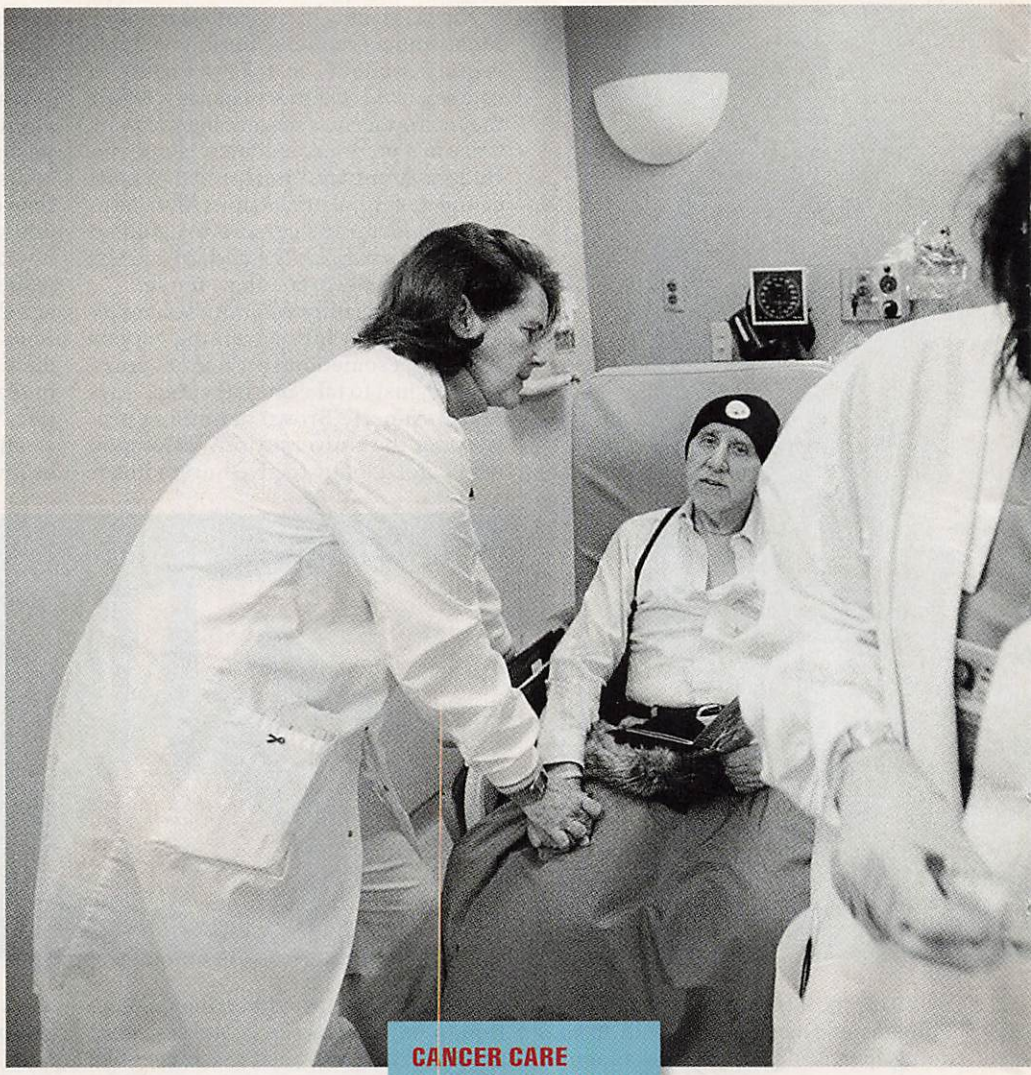
Nursing schools would have to increase enrollment by 40 percent annually just to compensate for retiring RNs. That's going to be hard, because schools recently had to turn away 26,000 qualified undergraduate candidates for lack of space: They don't have enough faculty. To deal with the problem, states and healthcare companies are luring nursing faculty by funding more positions. Buerhaus predicts more already-trained nurses will be brought in from abroad. Yet it may not be enough: Seventy-eight million graying baby boomers will contribute to a 40 percent increase in demand for hospital nurses over the next two decades. *–A.C.M.*



SOURCE: BUREAU OF HEALTH PROFESSIONS

says. "We can take better care of our patients if we use our own judgment, provided we know them and fully understand the course of their disease." As for that nurse's cap? "I wore it for a few months," says Welsh. Then she threw it out.

Balancing act. The ability of nurses to balance complex elements of long-term care while acting as counselors has made them a good fit as case managers. They work as the primary contact for patients, like the elderly, who have complex treatment plans. They can help eliminate frustrating redundancies among various doctors' offices and keep a constant record of detailed medical regimens. In San Francisco, gerontology expert and nurse Monika Pettross started her own case-manager business four years ago. One year into the venture, she began working with an elderly woman whose family found a suicide note in her home. Pettross, 32, discovered that some of the patient's medications could badly interact and lead to depression. After suggesting changes to the woman's prescriptions, she helped place her in a therapy program and counseled the family on how best to offer support. After two months, the woman was looking for a part-time job. Pettross still works with her today. "This work is so important I can't take off a badge in my free time and walk away from it," says Pettross.



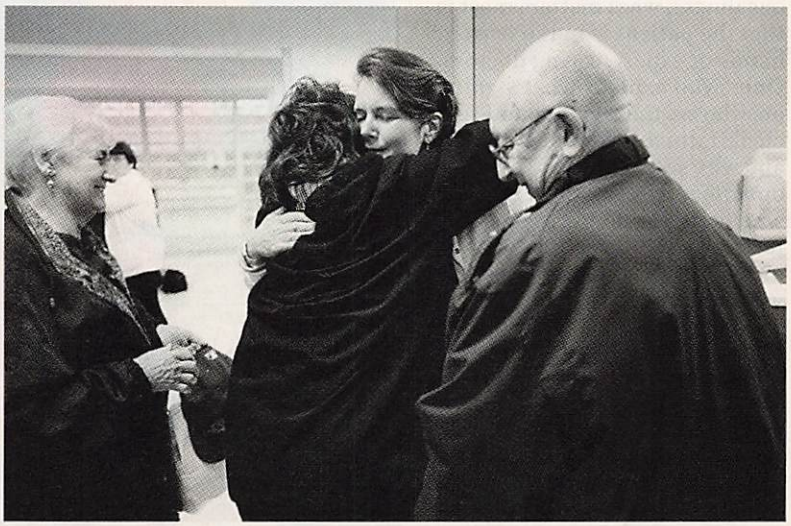
CANCER CARE
Clockwise: Oncology nurse Ann Welsh holds a patient's hand while giving treatment, rushes to an appointment, and hugs another patient's daughter.

Pettross is on to something. As people live longer and the nation's 78 million baby boomers approach retirement, more nurses are taking on elder care. The federal National Institute of Nursing Research is devoting millions of research dollars to the topic. One project explored the effect of delivering education and follow-up care at home to older patients hospitalized for heart trouble, says institute director Patricia Grady. Home delivery decreased the number of visits to the hospital, saving $4,845 in Medicare expenses per patient.

Nurses are also walking the cutting edge of health technology. They are at the vanguard in shifting hospitals away from mountains of problematic paper patient charts to automated, computer-based systems that cut down on delays and errors, says Scott Young, director of health information technology at the federal Agency for Health Research and Quality. About an hour south of Pittsburgh at Uniontown Hospital, Chief Nursing Officer Rebecca Ambrosini is one of those pioneers. Tired of 40-plus-page medical charts that "were never where we needed them when we needed them," she helped make a monumental change. After two years of work, nearly 85 percent of Uniontown's patient information is now available in a user-friendly desktop program called PowerChart. Only about 13 percent of U.S. hospitals have done anything like this.

The Uniontown system not only records patients' vital stats, like allergies and blood pressure, but also automatically sends doctors' orders to nurses, organizes reminders on necessary lab work, and sets up schedules free of hassles like double booking. The program also fires off automatic requests for help from social workers and even interpreters if one is needed. "Before, you had to pick up a phone and call for this assistance—if you remembered," says Darlene Ferguson, a critical-care nurse who is now Uniontown's director of clinical informatics and runs the system on a day-to-day basis. "We would grab a paper towel, write down what we needed, and stuff it in a pocket."

New ventures. At first, this high-tech onslaught made some Uniontown nurses a little nervous. "Some people talked about quitting" because they were worried about using computers, says registered nurse Donna Martin. But Ambrosini and Ferguson ran hours of workshops to get everyone up to speed. Now, wireless PowerChart workstations



on wheels line the beige hallways at the 230-bed facility. Nurses roll the computers into patients' rooms to take information and update charts with a keyboard and mouse rather than paper and pencil. There also are computer stations that are built into the walls and fold up like Murphy beds.

Nurses are also gaining ground in one of the fastest-growing areas of medical practice: genetics. According to Grady, of the nursing research institute, it makes sense for nurses to be involved in this fast-moving field because while genes may put patients at risk for health problems, changes in lifestyle and habits—a topic close to nurses' hearts—can help mitigate them. One recipient of the institute's funding is Lorraine Frazier, who holds a doctorate in nursing, a postdoc in genetics, and a teaching position at the University of Texas at Houston College of Nursing. Several years ago, when she first told a molecular medicine researcher that she wanted to work with him, "he was surprised," she says. "No nurse had ever asked to do that. Then, he asked me what nurses do." Now he knows. Frazier runs studies looking at how genetics shape the risks faced by patients with unstable heart disease; the results will eventually help tailor treatments for these patients.

For all its advances, nursing is still bedeviled by one old problem: lack of respect. When it comes to funding for nursing research, for instance, the money is a trickle. The nursing institute's budget makes up just 0.5 percent of the overall research pot at the National Institutes of Health. And according to a recent survey from VHA, a Texas-based healthcare cooperative, disrespect often takes a more direct, virulent form: abuse by doctors. Hospital nurses report vicious arguments. This toxic environment causes a breakdown in communication that can adversely affect care.

Down in Grantsville, nurse practitioner Ritchie hopes that the research that is going on will not just win more respect one day but will also help her patients with chronic illnesses. In her green cargo pants, black turtleneck (from which hangs her ever present stethoscope), and lug-soled boots, Ritchie ducks from crowded office to examining room to the "extra medicine" supply closet as country music plays on a boombox. She tells Harry Curry she'll go to Wal-Mart and buy him more of the salve he likes to rub on his dry, scaly shins. Then she tells another patient, Delberta Hickman, that it's OK to trust in Jesus to heal her diabetes but that medicine can help, too. She gives a 15-year-old girl free antibiotics and an enormous stack of condoms. "I plan to stay here," says Ritchie. "I couldn't leave my patients."

It's a simple thing really, says Uniontown's Ferguson: "A nurse always wants to make things better." ●

TEAMING UP

BY BERNADINE HEALY, M.D.

A young girl with a ruptured appendix; a middle-aged man with a massive heart attack; a mother of three with a scary lump in her breast. Or perhaps it's your mother who fell on the pavement and broke her hip. Or your son who just attempted suicide at college. Or your husband, whose spleen began leaking after an automobile accident. These are everyday events in the world of medicine, but they are all personal crises that quickly make most other everyday things seem trivial.

At those moments of treacherous illness, what matters most is that the patient is in the trusted hands of expert, caring doctors. Ones who explain what's going on, who are there with round-the-clock ministrations if need be, and who secure the best possible outcome. This is the expected way, honoring no clock or self-interest. And this is the stuff of medicine that makes nice people want to be doctors.

There is no greater thrill than seeing a sick patient heal. No greater joy than knowing hard-earned human efforts made a difference. But to achieve that in today's world, doctors can't fly solo anymore. For one thing, by today's rules no docs should be working around the clock; they need to be spelled by rested colleagues. Beyond that, however, medical advances have led to an ever finer carving of medical disciplines into specialties and subspecialties, driven by scientific discovery, which has brought good results in the curing or quelling of human disease.

Uberdocs. But this is recent history. Surgery was medicine's first one-on-one therapeutic specialty, flowering over the past 100 years. It was enabled not only by understanding infection and its prevention through clean hands, masks, rubber gloves, and sterilized instruments but also by the discovery of anesthesia. Without anesthesia, doctors dared not penetrate the belly or chest or drill into the skull. But with it, and accompanied by postoperative teams specialized in intensive care, surgeons began to cure many diseases that, left to their natural course, were killers. The surgeon became the überdoctor, the center of hospital life, and the ultimate healing hands.

Further medical advances ushered in other disciplines to rival surgery, using less blunt instruments. The internist, for example, started as the learned diagnostician who grasped the disease, pontificated on its outcome, and called in surgeons as needed. In those good old days of the solo doctor making house visits late into the night, his signature black bag was actually pretty empty—and what was there often did more bad than good. It was Oliver Wendell Holmes Sr., the renowned Boston physician and father of the famous Supreme Court justice, who summed it up in a speech before the Massachusetts Medical Society in 1860. After deriding the use of emetics, cathartics, blistering agents, and opium, he told his colleagues that if the whole existing formulary of drugs and potions available to them were sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fish.

In the good old days, the solo doc's signature black bag was actually pretty empty.

Drug therapy was mostly quackery back then. Since, research breakthroughs have turned medicinals into rational, safe, and dose-specific therapies. Bearing veritable nanoscalpels in the form of drugs that zero in on a disease pathway invisible to the eye or even the microscope, internists rose alongside surgeons as healers. Much of the diagnostic work was turned over to newer specialties. For example, CT scans and MRIs give physicians the X-ray vision to peer inside a troubled body; and sonograms turn the noises of the stethoscope into images of a beating heart or a growing fetus. Diagnosis got better and much easier on the patient—but high-tech and expensive. This pattern has been replicated in virtually every domain of medicine. At the same time, the general field of nursing spawned nurse practitioners, allied health therapists, and physician assistants to complement medical expertise in the vastly more complex care of both the healthy and the sick.

Through necessity and opportunity, medicine has become a huge group effort. The titans of yesterday fought hard for their autonomy and happily polished their individual pedestals of near godliness. Yet, the wisest of them set the stage for their own toppling by embracing the endless frontier of medical science, which ultimately transformed the way we give care. But, solo or group, yesterday or today, on the frontier or in the midst of today's fast-paced clinic, the practice of medicine by all its participants has never been easy. It comes with long and continued study, hard physical and mental work, and heavy responsibility. Plus, it demands a piece of one's soul. Future doc-

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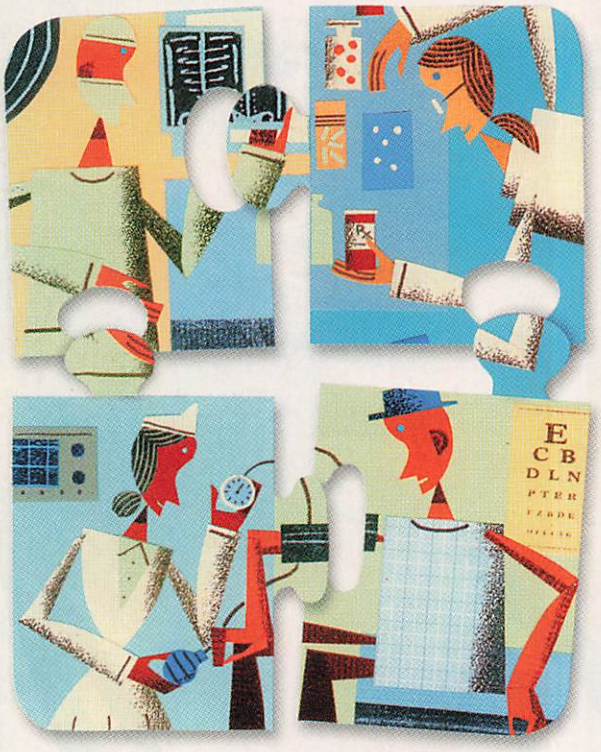
tors, nurses, and other health specialists always have been chosen not just for their smarts but also for their humanitarian values. They must be kind, merciful, and sympathetic to those they care for, whether the patient is old or young, rich or poor, appreciative or ornery.

Money is not an unimportant issue in the practice of modern medicine. Professional ethics dictate that payment must be secondary to the first interest of doing what's right for patients. Yet mercy and money have always been a tricky combination. In his famous almanac, Ben Franklin had a few gibes for doctors of his day: "God heals and the doctor takes fees." That hint of resentment came at a time when doctors were close to beggars and medicine a trivial part of the nation's economy. Today, the medical professions surely help the good Lord out, but the financial cost is mighty. Healthcare consumes 1 out of every 7 dollars of our national economy, and, as policy wags note, most of it is driven by the physician's pen.

There is an old saying that a physician is one upon whom we set our hopes when ill—and our dogs when well. That's easy to do, since at any one time most people are well and there's a certain suspicion about hefty resources being consumed by the ill. The steady, four-decade rise in health insurance costs, both government and private, has made modern healthcare possible. But at the same time it has introduced a new and less solicitous interest in between doctor and patient—that anonymous, often heavy-handed "third-party payer" holding most of the dollars.

Doctors have gripes galore about the third parties looming large at the bedside and in the examining rooms who effectively drive care by setting fees, dictating benefits, even making medical decisions such as whether a patient can have an extra hospital day or be allowed an MRI. It's legitimate for payers to question expenses, but it's also hard for the solo practitioner to stand up and be heard in this environment.



We might learn something about teamwork from the New England Patriots' Coach Bill Belichick.

That brings us squarely to the question: What is replacing our romantic notion of the solitary, autonomous doctor? Ideally, one would hope for an integrated team working together on behalf of common medical goals, with the patient at the center. This, as opposed to what so often happens today: a loosely allied group of independent, unrelated practitioners drawn together in a defensive huddle to meet the needs of insurance contracting and managed care.

The integrated team model has been around a long time, but it is still the exception in today's private medical practice. It was pioneered by the Mayo Clinic more than 80 years ago. The architect was the surgeon W. W. Mayo, who was fond of saying, "No man is big enough to be independent of others." Mayo and his two surgeon sons, Will and Charlie, developed a model of "cooperative individualism," in which top-notch physicians from all disciplines were carefully selected to work together in salaried positions. Salary was key, because it meant the docs were not answerable to accountants for their medical decisions, and it was understood upfront that some of their fees would be plowed back into the institution. Many in the medical field saw such a cooperative venture as downgrading the medical profession, by making doctors cogs in a wheel. Ironically, the problem today is that all too many individual practitioners see themselves as little more than cogs—but in a broken wheel.

Sidelines. The clinic model, or some variation of an integrated team, is just what medicine needs today. It will work, however, only if it comes with the purpose and the faith that this will bring better care of the patient and enable the squeezed practitioners to remember what brought them to medicine in the first place. Indeed, the 21st century finds physicians and their patients struggling to meet the medical and economic demands that necessitate team-oriented healthcare. Here we might learn a thing or two from America's most favorite spectator sport, football, and one of football's best, Coach Bill Belichick of the New England Patriots.

Belichick astounds the sports world by his ability to build a Super Bowl-winning team of solid but not splendiferous players. His strategy seems simple: Accentuate any given player's strength, and manage around the weaknesses, something you can do if you have a versatile team. He is proud of his team for being made up of unselfish guys, who work hard, respect him and one another, and on the field are committed only to winning. A group of comparable or even higher-quality athletes, unable to consistently work in unison, would be self-defeating.

That is a lesson for the kind of teamwork that is essential in the medical field now and as we look ahead. It comes with benefits, including pride in doing better for patients, intellectual stimulation, fewer administrative hassles from the third parties, and more reasonable work hours. And, as in football, a successful medical team's glue is that intangible called faith—in one another and those they serve. That timeless ethos is captured in words penned by the Cleveland Clinic's late surgeon George Crile Jr. in 1955: "No physician, sleepless and worried about a patient, can return to the hospital in the midnight hours without feeling the importance of his faith. The dim corridor is silent; the doors are closed. At the end of the corridor in the glow of the desk lamp, the nurse watches over those who sleep or lie lonely and wait behind closed doors. No physician entering the hospital in these quiet hours can help feeling that the medical institution of which he is part is in essence religious, that it is built on trust. No physician can fail to be proud that he is part of his patient's faith." ●

(Continued from Page 76) dle-income workers by as much as 25 percent over 30 years. It would thus preclude many seniors from enjoying the benefits of rising standards of living. A solution here is to protect workers at the lower end of the income spectrum by retaining benefits according to wage rises for them but lowering benefits to price indexing for the higher levels. Or some mix of the two.

There is another worry—that the trust fund is a tempting piggy bank for congressional spendthrifts. The head of the Social Security Administration made an interesting proposal that would both protect the fund and possibly increase it: Free the program to invest in stocks and bonds. Properly invested in standard balanced accounts, the fund could earn about 4.9 percent a year after expenses—much higher than the return on all those treasury bonds, thus improving its long-term solvency.

President Bush has a different answer to all of the above. In pursuit of his "ownership society," he wants to move Social Security toward "greater individual opportunity, risk, and reward" by allowing individuals to carve themselves private investment accounts out of Social Security payroll taxes, much like a 401(k) plan. This raises a whole host of problems. It discriminates against poorer workers, for one thing. Why? Because the lower your income, the less you have to invest, and the smaller your return will be. The Bush plan offers nothing close to the financial security of the existing program. Then there's this: Are individual investors sophisticated enough to match the higher returns now being forecast? At least 10 studies analyzed by the Securities and Exchange Commission indicate a disturbing level of financial illiteracy. Only 12 percent of the investors studied could distinguish between a load and a no-load mutual fund; only 14 percent understood the difference between a growth stock and an income stock; only 38 percent knew that when interest rates rise, bond prices fall; almost half somehow believed that diversification guarantees that their portfolio would not suffer if the market dropped; and 40 percent thought that the trust fund's operating costs would not be deducted from their investment return.

Experience with 401(k) retirement plans shows that many people fail to invest and to diversify sufficiently to maximize their returns. Many make mistakes at each step of the way, not because they are stupid but because they live busy, complicated lives, focusing on work and family, and lack the time to become financial experts. Many people are shrewd enough to understand this, which is why they invest in mutual funds. Those 50 percent or more who are not in the stock market presumably have even less knowledge and experience.

Furthermore, historical stock-market returns are not a guide for future performance. A lot depends on when you buy or sell, especially when America faces not only dramatic fiscal problems but a threat to profit margins in growing global competition, particularly from India and China. If someone retires after the market dives, he or she could lose a good chunk of retirement savings. The market, after all, fell by 45 percent in real terms between 1968 and 1978—never mind the bust between 2000 and 2002. Individuals would be glad to pocket gains, but if millions of retirees suffered dramatic losses, there would be enormous political pressure to come to their rescue. We would very likely end up privatizing gains and socializing the losses.

Upside down. The macroeconomic consequences of privatization of Social Security are equally significant. Privatization fails to address the long-term gap in the program's financial resources. It would make things worse because the government would have to borrow the money that otherwise would be paid into the system. This amounts to roughly $2 trillion in the first decade, over $3 trillion in the second decade, and approximately $5 trillion in each of the third and fourth decades—a run-up of about $15 trillion in the national debt, based on a Congressional Budget Office estimate widely believed to be close to the Bush plan. Privatization does not begin to save money until 2050—hardly a solution to a crisis the administration has described as imminent. Even worse, it might create a fiscal crisis, inflating future budget deficits to unprecedented levels and sending the economy into a tailspin.

> Social Security was not meant to re-create the free market but to buffer the needy from its vagaries.

Of course, the idea of an "ownership society" is to change the relationship of Americans to their government so they look less to Washington than to themselves (and, just maybe, vote more Republican). No doubt some Americans could build savings and more wealth and have a nest egg for retirement. No doubt there is value in savings and self-reliance, in making private investment decisions, planning ahead, and increasing distance from the government. But there are other values in the very title of the program—Social Security. "Social" surely implies a contract to help manage poverty among the old and to know that our society provides a minimum income for all of our fellow citizens in their retirement years. And "security" means buffering the harshness and cruelty of the markets so that the well-being of the elderly is not dependent on shrewd stock picks and hot mutual funds that enrich some but fail the very people who need Social Security benefits the most.

Privatization thus gets things upside down. Social Security was not meant to re-create the free market; it was intended to insure against the vagaries and cruelties of the market and to permit Americans to count on the promise that the next generation will take care of them in their old age. ●

A 'cure' worse than the cold

FIRE AND FREEDOM CAPTURED THE HEADlines of the president's stirring inaugural address, but it was a handful of words toward the end of the speech that are likely to have the most profound impact on the daily lives of millions of Americans. After a nod to landmark legislation like the Homestead Act, the Social Security Act, and the GI Bill of Rights, the president said, "And now we will extend this vision by reforming great institutions to serve the needs of our time. . . . We will . . . build an ownership society."

It is clear that President Bush's first "ownership" priority is Social Security. Typically, this is presented as "reforming" Social Security or "saving" it from collapse. But what are the realities behind the easy rhetoric? Social Security is the most popular and universal of any of our government programs because it guarantees a pension to anyone who has contributed to the system throughout his working years. It's the cornerstone of life for nearly 48 million people—retirees, dependents, survivors of deceased workers, and the disabled—all of whom receive a check like clockwork every month. Millions more of today's workers will come to rely on those checks in the years ahead. Many don't think much about that fact, and few realize just how much of a nest egg they're going to need. An American reaching the retirement age of 65 today has an average life expectancy of 18 years, which means that roughly half of those who reach 65 can expect to live longer than 18 years. Four out of 10 have no non-work-related retirement savings. Six out of 10 haven't even tried to estimate what they'll need. They rely vaguely on Social Security, but how far will it carry them into their 70s and 80s? How serious is the "crisis" they hear about? What are the implications of "reform"?

Hand-wringing. Social Security pensions were indexed to the rate of inflation in the 1960s and 1970s, transforming the lives of millions of Americans by dramatically diminishing poverty among the elderly. Now only 10 percent of those over 65 live in poverty—2 points lower than the national poverty rate. Roughly two thirds of people ages 65 and over depend on Social Security for at least half their income, and roughly 20 percent rely on it for their entire income. Currently, the payroll tax brings in more dollars than it pays out in benefits. The surplus, now roughly $180 billion a year, is invested in treasury securities and deposited into a trust fund, which now holds over $1.5 trillion of these notes. As the baby boomers begin to retire, the system will go into deficit around 2018, requiring drawing down on the fund. By that time the fund will exceed $3 trillion, so it will be in the black until around 2042, using the Social Security Administration's conservative economic and demographic assumptions, or 2052, using the assumptions of the nonpartisan Congressional Budget Office. Even if the system exhausts its reserves, payroll taxes will continue to roll in, enabling at least 73 percent of scheduled benefits to be paid out.

> Why privatizing Social Security could cause a whole lot more problems than it solves

In other words, there is no current financial crisis in the program. So, what's with all the hand-wringing? Well, if you make pessimistic predictions about economic growth, immigration, and wage inflation, the projected revenues may not be enough to pay benefits. The Social Security actuaries, for instance, project that growth will average only 1.6 percent after 2010, about half the rate we have enjoyed in the past century. But if the economy grows at anywhere near the levels that Bush's own budget experts project, the surplus, in effect, would never run out. And more-optimistic forecasts than those of the Social Security actuaries are supported by the recent history of economic and demographic trends.

Most important, to the extent that there is a deficit, it could be covered by a variety of modest combinations of tax hikes and benefit cuts—each of them quite manageable.

There are many options that would not put at risk the essential elements of Social Security. A careful study by AARP estimates that 43 percent of the Social Security deficit projection would be met by raising the cap on taxable wages from $90,000 to $140,000; 38 percent would be covered until 2083 by raising to 70 the retirement age for full benefits; a quarter-percentage-point increase in the payroll tax for employees and employers would cover 24 percent; requiring state and local government workers to join would cover 9 percent. Yet another approach implicit in the president's program is to decelerate increases in benefits by raising them in line with prices, not wages. This readjustment would eliminate the 75-year projected deficit of Social Security, but it would have a major impact on low-wage earners who depend almost entirely on Social Security, and it would reduce benefits for mid- *(Continued on Page 75)*

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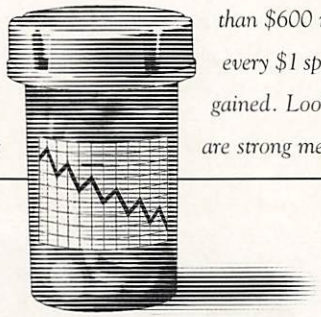

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